NC Medicaid Managed Care: What Advocates Need to Know[1]:

Follow up answers to questions asked during the webinar

The webinar slides referenced in this document were sent in the same email as this document, but should also be able to be accessed through this link to the slides.

This document does not use exactly the questions asked during the webinar. Questions that were similar were combined and questions have also been edited for clarity. Also, we have grouped the questions together by subject rather than the order they were asked.

Please note, the answers are based on current knowledge and are intended for general application, not as answers to any individual's particular situation.

Q&A

I. Enrollment

A. Enrollment Process

1. Is there a blank enrollment form available?

   A: The enrollment forms are by region or group. Sample forms are available on the NC DHHS County Playbook page under Enrollment Packet. This will tell you the information that will be asked. However, to actually enroll, an individual should contact the enrollment broker through the different available mechanisms, including their website, to enroll or request a form.

2. Will this change how individuals apply for Medicaid, and where they apply?

   A: No, managed care does not change where or how a person applies for Medicaid in NC.

3. When applying for Medicaid for the first time, will the plan be chosen at the time of application at DSS? What happens if a person does not chose a plan, will they be automatically enrolled in a plan?

   A: The NC Medicaid application now asks new applicants to choose a plan. Applicants who do not choose a plan will be auto assigned to a PHP (prepaid health plan) unless DHHS has enough data to know that the new applicant is excluded or exempt. Everyone will have 90 days to change plans after enrolled in a plan. Those who believe they are exempt or excluded can request disenrollment from managed care at any time. Medicaid

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Direct (traditional fee-for-service Medicaid) will cover services for any period of Medicaid eligibility prior to enrollment in a plan, including up to 3 months prior to application.

4. So a person who has Medicaid for themselves and their children, when they are enrolling are they doing this separate or as one plan (family plan)?

   A: This is up to the family to decide.

5. If the enrollment broker isn't helping a family who shouldn't have to enroll and is sending them back to DSS and DSS isn't returning calls, what recourse do they have right now since the ombudsman program isn't up and running yet?

   A: The family has until May 14 to enroll. The ombudsman program will be operational on April 15, so an individual or family can wait until they can contact the ombudsman program. But a person can also contact the DHHS Medicaid Contact Center or call their local Legal Aid of NC or legal services office.

6. How do people who have not received enrollment packets sign up for NC Medicaid managed care?

   A: An individual who needs or wants to enroll should contact the enrollment broker to find out more about plans and enroll. The enrollment broker can be contacted in a variety of ways, as explained on the enrollment broker website: https://ncmedicaidplans.gov/home.

7. In working with elderly clients at the Council in Aging, they do not use websites and do not understand this. Calling multiple PHPs is very intimidating. What is in place to help with these issues?

   A: For enrollment questions, call the enrollment broker first. If that does not work, call the ombudsman after April 15.

8. Just to clarify, exempt people can **choose** to enroll, right?

   A: Yes, people who are exempt may choose to enroll, but they should evaluate such a choice carefully as they may not be able to continue receiving certain services that they currently receive. For example, a person receiving certain services from an LME/MCO (Local Management Entity/Managed Care Organization), e.g., Vaya Health, currently that are not offered under a PHP, such as Assertive Community Treatment, may no longer be able to access those services if they choose to enroll in managed care. In addition, as slide 28 and this document from NC DHHS explains, there is a difference between those who are **exempt**, such as federally recognized tribal members, who can choose to enroll, and those who are **excluded**, such as people receiving Innovations Waiver services, who cannot enroll.

9. Is the state or enrollment broker doing any special outreach for Medicaid recipients who may have recently become homeless and do not have an address or their address is incorrect on their 834 form?

   A: Not that we are aware of.

10. Is there any discussion to reach out to those who have not enrolled prior to autoenrollment to assess any barriers in doing so? Some of them are non-English speaking, may have low literacy levels, or may not understand what they are supposed to do?

    A: We are not aware of a plan to do such outreach. However, people who are autoenrolled will be able to change plans until the end of September.

11. Will the Enrollment Broker be able to offer interpretation? In other languages?

    A: Yes.

12. Have they hired enrollment brokers for in-person assistance?

    A: Not that we are aware of.

13. Can SHIIP counselors play a role in plan selection??

    A: SHIIP (Seniors' Health Insurance Information Program) counselors are not trained to do this. Enrollment broker staff are.

14. If you are eligible to stay in NC Medicaid Direct, will you need to take action in the 60-day window?

    A: Only if the individual has been sent a notice stating they must enroll.

15. Some participants are exempt from enrolling, so am I correct in assuming that if we have not received the packet at this point, that we are exempt from enrolling and will continue with the same coverage that we currently have with no issues? For example, if my child has ID/DD and is medically fragile, they should be exempt and not have to do anything?

    A: There is not currently a notice for the "excluded" population (see this state document for a list of notices by population). So if a person is in an excluded category, such as receiving Innovations or CAP/C waiver services, and does not receive a notice, this is expected. Many people who are exempt will receive the exempt notice, but the notice process is not perfect. If a person has not received the notice to enroll or received other notices or contact about enrolling in managed care, then they are likely excluded unless DSS does not have their current address. However, a person should be able to call the enrollment broker to confirm they are identified as exempt or excluded.

B. Who Has to Enroll/Who is Exempt?

1. Who is eligible for Medicaid Direct?

   A: Anyone who is exempt has the option to stay in Medicaid Direct. Anyone who is excluded must stay in Medicaid Direct. See slide 28 and also this list of who is mandatory enrollment, exempt, and excluded.

2. Is everyone who is exempt eventually going to be in managed care?

   A: That is currently the plan.

3. What does CDSA (Children's Developmental Services Agencies) being carved-out mean? Does this mean that all services provided by CDSAs (including ST, OT, etc.) provided under the CDSA umbrella will stay fee for service? And that contracted CDSA providers are exempt? Or just that they do not have to contract with managed care for those CDSA services, but would for Medicaid-funded OT, PT, etc. that is not covered under CDSA?

   A: There is a fact sheet on CDSA services and the relationship to managed care mentioned during webinar. As the fact sheet explains, services billed by or to the CDSA are carved out but services billed directly to NCTRACKS by independent practitioners are not carved out even though included in the CDSA plan. Those providers need to enroll in the PHPs.

4. So is NC Health Choice part of the prepaid health plan/managed care or tailored plans?

   A: NC Health Choice beneficiaries have to enroll in a standard plan/PHP. Tailored Plans will not cover NC Health Choice beneficiaries.

5. How do I get a newborn who may be born in July enrolled in a plan on time? Is there a transition period for newborns?

A. The Medicaid application now asks new applicants to choose a plan. Applicants who do not choose a plan will be auto assigned to a PHP unless DHHS has enough data to know that the new applicant is excluded or exempt. Everyone will have 90 days to change plans after enrolled in a plan. Those who believe they are exempt or excluded can request disenrollment from managed care at any time. Medicaid Direct (traditional Medicaid) will cover services for any period of Medicaid eligibility prior to enrollment in a plan, including up to 3 months prior to application. For newborns, an application is not required but county DSSs should provide the opportunity to choose a plan. Otherwise the process is the same.

6. What will be considered severe mental, substance, or physical?

   A: See slide number 31 and the links at bottom of that slide.

7. Will Medicaid family planning convert to managed care?

   A: No. Those with Medicaid for family planning services only are excluded (see the exclusion list on this state factsheet).

8. I would like to clarify that under the "exempt" list are those on "Refugee Medicaid" [which technically should be "Refugee Medical Assistance"]. Only a limited number of "refugee" populations are on Refugee Medical Assistance. This does not include all "refugees". Most refugee newcomers are in other Medicaid programs such as Families and Children and are not exempt.

   A: This is correct.

9. Is a child on SSI Medicaid (but not CAP/C (community alternatives program for children) or other waivers) required to enroll?

   A: Yes, unless the child meets another exemption.

10. How does one be excluded if medically needy but received a letter to select a plan?

    A: See slide number 32.

11. Is an autism diagnosis considered medically needy? Services were listed as “DRAFT” under standard plans in one of the slides

    A: Medically needy refers to an eligibility category in which a beneficiary must meet a deductible before Medicaid begins. It is not about a person’s diagnoses or needs. However, a child with autism will likely meet the criteria to be excluded as identified in slide number 31. But see the information linked on that slide for more information about excluded diagnoses and services.

12. What about people who have BCCCP Medicaid (breast and cervical cancer control program) or are they considered exempt from this?

    A: They are not listed as excluded or exempt in the statute or DHHS materials.

13. I heard that children adopted through DSS (along with foster children) are excluded. Is that in 'print' anywhere?

    A: Beneficiaries receiving IV-E Adoption assistance or who formerly received it or who are under age 26 formerly in foster care or formerly getting adoption assistance are excluded. N.C. General Statute 108D-40(a)(13)(c). But also see the next answer about children eligible for IHS.

14. So does that mean that some children in foster care may be exempt if they have never been on Medicaid and came into foster care recently?

A: Children in foster care are generally excluded until the specialized plan for them begins. However, a child who is a member of a federally recognized tribe or otherwise eligible for IHS may, but does not have to, enroll in the tribal option plan.

15. What about coverage for parents of kids who are in foster care who are still in their parents' custody (not in DSS custody)?

    A: If a child is in DSS legal custody, they should be excluded even if living with parents. Whether a parent needs to enroll in managed care is based on their Medicaid eligibility, not their child's.

16. What happens with the scenario of a child living with a relative, not under the supervision of DSS or "officially" in foster care. The child is currently on Medicaid, but the remainder of the family she is living with is not on Medicaid. Does this child need to be enrolled in managed care?

    A: This child must enroll in a plan unless she meets another exemption or exclusion.

17. What about individuals in jails which are county and not state level as with prisons?

    A: The statute excludes inmates in prisons. This should include county jails.

18. Slide 31 talks about DJJ (juvenile justice) involved as a path to stay in Medicaid direct but some folks who may be connected with DJJ may be linked during a complaint from the school and have the ability to be diverted. Can you define juvenile justice-involved? Or how this population is identified/detected as being linked to DJJ?

    A: The statute excludes "Children and youth involved with the Division of Juvenile Justice of the Department of Public Safety and Delinquency Prevention Programs who meet criteria established by the Department of Health and Human Services." Department policy papers do not discuss this population, other than to indicate in one of the tailored plan papers that involvement with the juvenile justice system would be considered sufficient to demonstrate functional impairment.

19. What about people who have BCBS & Medicaid?

    A: People with both private health insurance and Medicaid, but not Medicare, are not excluded.

20. If a dual eligible recipient has a Medicare Advantage Plan, will they have to enroll?

    A: No, they cannot enroll.

21. Are dual eligible individuals (those with Medicare and Medicaid) exempt/excluded or just delayed enrollment until July 2021?

A: Dual eligibles are excluded until further notice.

22. How does the QMB program, under which Medicaid pays for a person's Medicare premium, work with managed care enrollment?

    A: QMB (also called MQB) beneficiaries are excluded because they have Medicare.

23. Can children stay fee for service/Medicaid Direct by diagnosis, and the parents pick something else for their own Medicaid plan?

    A: Yes, whether exempt or excluded can be different for different family members.

24. If you are on the CAP-DA (community alternatives program for disabled adults) waitlist should you enroll or are you exempt?

    A: Those on the CAP-DA waiting list but not enrolled yet are not exempt or excluded unless on another basis (e.g., they have Medicare).

C. Tailored Plan v. Standard Plan

1. I thought that if someone on the Innovations waiver waiting list enrolled in a standard plan, then they would lose their spot on the waiting list. Is that not true?

   A: No, enrollment in a managed care standard plan should not change Innovations or TBI waiver (traumatic brain injury waiver) waitlist placement.

2. Can a person keep their Innovations waiver services and enroll in one of the plans?

   A: No. Innovations Waiver participants may not enroll in a Standard Plan and keep waiver services. They will be enrolled in Tailored Plans when those are implemented in 2022.

3. Will CAP- DA switch to a tailored plan?

   A: No. There is currently no plan to move CAP-DA enrollees to any managed care plan.

4. So any member who is getting respite services through an LME will need stay with traditional Medicaid?

   A: Yes. If you are receiving any services through a LME-MCO that are not part of the Standard Plans you will need to stay in Medicaid Direct and your LME-MCO for now.

5. If you are on the CAP-DA wait list, are you exempt?

   A: Those on the CAP-DA waiting list but not enrolled in the program yet are not exempt or excluded from managed care enrollment unless on another basis (e.g., they have Medicare).

6. Where do families whose child is on the Innovations waiver waitlist find out the relative value of Standard Plan vs. Tailored Plan?

   A: There is no way to directly compare Standard and Tailored Plans right now because Tailored Plans are still under development. To decide whether you would like to enroll in a Standard Plan before Tailored Plans are implemented you will need to review plan details at NCMedicaidPlans.com. Also, if you are receiving any services through your LME-MCO that are not part of Standard Plans, you will lose those services if you enroll in a Standard Plan.

7. If I received a letter to enroll and I have Innovation waiver services, what should I do? Contact the Enrollment Broker?

   A: Yes, contact the Enrollment Broker and tell them you have Innovation waiver services and follow their instructions, which may include filing a Medicaid Direct form.

8. How are they defining serious ID/DD (intellectual disability/developmental disability)? Is substance use included in exemption? (the slide just says "mental health"). Will CAP switch to tailored plans?

   A: See the documents linked in slide 31. The first document, the updated criteria for tailored plan exemption, includes lists of diagnoses and services, along with other criteria that indicate whether a person is eligible to stay in Medicaid Direct based on diagnosis. These lists include ID/DD, mental health, and substance use disorder diagnoses and services. As for CAP, there are no current plans to switch CAP-DA to tailored plans; the Innovations and TBI waivers are to be under the tailored plans.

9. What does draft mean for autism services under standard plans?

   A: There have been no changes to plans to cover a broader range of autism supports. Children may be eligible through the EPSDT benefit (see question 2 under Services Generally section) if treatment is medically necessary to prevent, treat, or ameliorate a condition.

10. Is substance use included in mental health plans?

    A: Some substance use disorder services are included in standard plans, but many of those services will only be available through the LME/MCOs until tailored plans begin and then those services will only be available through tailored plans. See slide 21 for more information on which services fall under which type of plan. A person may be eligible to stay in Medicaid Direct because of a substance use disorder diagnosis or use of services, for more information on which diagnoses and services, see the updated criteria for tailored plan exemption.

11. Is the application for the Innovations waiver process going to be more difficult?

A: The application process for the Innovations waiver is not currently expected to change.

12. Will people lose their place on the Innovations wait list if you mistakenly enroll in a standard plan?

    A: No. People on the Innovations waitlist, also known as the Registry of Unmet Need, should not lose their place if enrolled in a standard plan. If they are currently receiving services from the LME/MCO, they would likely lose those services if they enroll in a standard plan.

13. What is the difference between PHP and LME/MCO?

    A: An LME/MCO is a type of PHP or prepaid health plan. For the purposes of this presentation we often used the term PHP to refer to the standard plans. A significant difference between the standard plans and an LME/MCO is that a standard plan will manage most physical and behavioral services, while an LME/MCO only manages behavioral health services. In the future, as LME/MCOs become tailored plans, they will take on physical health services.

D. Disenrollment from Managed Care & Changing Plans

1. Ability to change plans at least twice or up to twice?

   A: Beneficiaries can change plans twice per year without a reason. After that they need a good reason until the following year.

2. If a plan disenrolls an individual, what happens at that point? The plans do not control Medicaid eligibility, do they?

   A: The person does not lose Medicaid coverage, but they will be moved to another plan or (if exempt or excluded) to Medicaid Direct.

3. I work with refugees who do not speak/read English or Spanish. What if they do nothing, are auto-enrolled into a plan in May, and then go to the regular doctor and find out the doctor does not participate in their assigned plan? Would they still be seen? Turned away? I know they can switch plans - can the clinic facilitate that at the time of appointment?

   A: If the doctor is out of network for the person's plan, the visit would likely been uncovered and that would likely mean the person would not be seen. A person has until the end of September to change plans for any reason. The clinic could direct the individual to the enrollment broker to see if they can change plans or to their current plan contact information to find an in-network clinician.

4. Is there a path for someone with MH/DD/SU health care needs to be transitioned out of standard plans whose needs exceed the standard plans' ability to manage the care back to the LME/MCO or tailored pans once they become available?

   A: Yes, this is covered by the Transition of Care policy. The plan must assist in this process.

5. If DSS takes a child into custody after they are enrolled for a managed care plan, are they switched to a non-exempt plan once they are considered a foster child?

   A: Yes, the child should be disenrolled from managed care.

6. So, patients undergoing chemotherapy treatments can switch back to regular Medicaid?

   A: Getting chemotherapy is not grounds for being exempt or excluded from managed care but transition of care protections may apply.

7. What are the protections against discriminatory practices that might cause someone to be dis-enrolled?

   A: There are federal laws that prohibit many types of discrimination by the plans, including based on a disability. These could be enforced by the state, in litigation, or by appealing the disenrollment decision. The ombudsman is a good first place to call.

8. What is "good cause" to change plans after the 90 day period?

   A: Moving out of a PHP service area, services needed that are not available from plan, complex medical conditions better served by a different plan, poor plan performance. See N.C. General Statute 108D-5.3 for details.

9. How often can you switch plans with good cause?

   A: There is a form to request a change of plans or disenrollment for good cause. The enrollment broker must assist. If the request is denied, an appeal can be filed.

10. Does the playbook outline how to change plans if needed? Can advocates assist with this process?

    A: The current playbooks do not. Advocates are allowed to assist in changing plans or in appealing denial of request.

11. If services are not available within a PHP, could this be an acceptable reason to change PHP?

    A: Yes. See N.C. General Statute 108D-5.3(c) for details.

E. Other Enrollment Questions

1. What would be the benefit of disenrolling from the new standard plans to stay with Medicaid Direct?

   A: Some mental health, developmental disability, and substance use disorder services are not available through plans (i.e., services currently provided through LME/MCOs). Also because standard plans operate their own network of providers, a person may have more provider choice in Medicaid direct. There are other differences that may impact a person's who is exempt from managed care may consider when evaluating whether to enroll in a standard plan now or not.

2. Are local health departments that do not provide primary care services carved out? So the LHD will not be on a tier?

   A: Medicaid services through local health departments are not carved out, but plans must contract with them to include them in their provider networks.

3. How can we find out whether our pharmacy is enrolled in the PBMs (pharmacy benefit managers) that manage the insurance? I do not get any response when I email CVS Caremark and Optum RX?

   A: Call the member services phone number for the plan. If you use the enrollment broker's provider search tool and search by organization, some pharmacies are listed there.

4. Some plans are region-specific, correct?

   A: Only two plans are region specific. See slides 12-13.

5. To your knowledge, are there any parts of the state where providers are not signing up with any of the Plans? In the past, we heard that many providers in the Charlotte area were not signing up with any.

   A: We do not have enough information yet to answer this but the provider search tool at the enrollment website has more info.

6. Does a family still select a standard plan for the PCP (primary care provider) even if the child has many specialists who are not all on the same plan?

   A: Unless exempt, the family still needs to choose a plan and PCP for the child. The family can use the provider search tool on the enrollment broker website or contact the enrollment broker to help figure out which plan includes current or preferred clinicians. The child may have to change specialists but transition of care protections apply.

7. How will people know to wait if their provider is not listed?

A: We hope the enrollment broker will help them with this question and provide information on provider networks, including their development.

8. All providers are available on any plan even if the provider is not on the plan the enrollee is on?

   A: No. Usually you are limited to providers in the network for the plan you are in.

9. The marketing information on each plan advertises various bells and whistles but nothing else really about why to choose a specific plan. Besides verifying that your preferred providers are on the plan, what are the other reasons you might pick a specific plan? Is there a change in what is covered too?

   A: The plans all have to follow current clinical policies. You could also research the performance of this plan in other states.

10. Will plans be in-network with providers only in their network? Rather, region?

    A: Usually you are limited to providers in-network for the plan you are in.

11. How do the regions impact children in foster care from a county other than where they are living? Example: I'm in region 5 but have a child in my home from region 6. It has been a challenge getting services for her in region 5.

    A: For now, children in foster care stay in Medicaid direct which means they can go to any Medicaid provider. When the foster care plan is launched, it is planned to be a statewide network.

II. Notices & Appeals

1. Why did they send enrollment letters to exempt groups?

   A: Because they have the choice to enroll in a plan. People who are in groups that are excluded, other than tribal members, generally did not receive letters regarding managed care, based on the enrollment packet notices listing.

2. At what reading level is the information written?

   A: It is supposed to be at a sixth grade reading level.

3. Can we get a link to the county playbook as well? Does this include notices in languages other than English? My clients have received letters regarding this change in English, an information provided via interpreter was not especially clear. There is a need in various areas of the state for materials and information in Swahili, Arabic, Nepali, and Vietnamese.

A: The County Playbook, including the Enrollment Packet includes the enrollment notices in Spanish and English, including the exempt notice.

If DHHS has a person identified as preferring Spanish materials in their system, they should receive a notice in Spanish. The notices should also have taglines telling people to call a number for accessibility and language requests.

4. Is the appeal process explained in Spanish and other languages?

   A: Yes, the process is explained in Spanish in the member handbook and on appealable notices, which also include taglines in other languages on where to call.

II. Services

A. Services Generally

1. What is "in lieu of " service?

   A: The plans can ask for state approval to add services or substitute a different service. All of the plans are offering extra services not covered under Medicaid Direct.

2. What is EPSDT?

   A: Early Periodic Screening, Diagnostic and Treatment. For more information about this important benefit, see this information from Disability Rights, NC. Link to Disability Rights, NC information Or this guide from CMS: Link to Guide from CMS

3. What is "children's screening" is that Health Check or EPSDT?

   A: EPSDT, as explained in the previous question, includes both screening and treatment. Health Check is what NC calls its Medicaid program for children, which is required to follow EPSDT requirements.

4. There should not be a disruption of services if a child is already receiving ABA services for example, correct?

   A: If the child is required to enroll in a plan, the plan will have to pay the same provider for 90 days unless the authorization period ends sooner. This time period should give a person a chance to switch to an in-network provider if their provider is not one, or for that provider to potentially contract with the plan. See slides 38-39.

5. How long is the transition of care period?

   A: Generally 90 days, but it can vary. See slides 38-39 and https://medicaid.ncdhhs.gov/transformation/care-management/transition-care.

6. If a Medicaid member needs to go to a skilled nursing facility or an assisted living facility will the managed care plan have to provide authorization prior to admission?

   A: Yes, it is likely prior authorization would be required prior to admission if the beneficiary is enrolled in a plan at the time. Nursing facility residents are only excluded from managed care after 90 days or more. For assisted living facilities, oftentimes a person needs certain Medicaid services, such as personal care services, in that facility that may need prior authorization.

7. Have the plans stated if they will cover telehealth at the same/similar rates as office visits?

   A: The issue of rates is outside our scope of expertise.

8. What about oral health benefits?

   A: Most oral health benefits are carved out of managed care. See slide 16.

9. Does the PHP's responsibility for transition of care include members who transition to an SNF (skilled nursing facility) and the duration of a long-term stay?

   A: After 90 days in SNF, the beneficiary leaves managed care.

10. What about the PBMs (pharmacy benefit managers) that are linked to these plans (e.g., CVS Caremark, OptumRx, PerformRx)?

    A: This is outside the scope of this webinar but if the beneficiary does not have access to the prescriptions they need they should call the ombudsman.

B. Non-Emergency Medical Transportation (NEMT)

1. For transportation, will non-English/non-Spanish speakers be able to call and get assistance in their language to schedule medical transport?

   A: Yes, plans must communicate in the beneficiary's preferred language and use qualified translators.

2. Under non-emergency transportation, will plans still provide mileage reimbursement?

   A: Mileage reimbursement should still be included as part of non-emergency medical transportation through the plans. Reimbursement will still depend on meeting policy requirements, like requesting reimbursement and the individual using their own vehicle.

3. What about members who receive daily transport to/from the facility-based daily services. How will this be scheduled under the plans?

A: Through the plan they are enrolled in unless excluded/exempt. If they are exempt or excluded, the transportation will be scheduled through DSS.

4. Will the non-emergency medical transportation for dually eligible individuals stay the same as it is now?

   A: Yes.

5. Some adults with disabilities need another adult with them on NEMT--will this be accommodated?

   A: Yes. That is required.

6. Will NEMT to specialists outside of the immediate local area be provided?

   A: Yes, if no closer provider is appropriate.

IV. Enrollment Broker v. Ombudsman

1. Since the Ombudsman and free legal services in this state are provided by the same organizations, who will be representing individuals in these appeals?

   A: Legal Aid of North Carolina, Charlotte Center for Legal Advocacy, Pisgah Legal Services, and Disability Rights NC will handle appeals, including referrals from the ombudsman. They are also recruiting and training pro bono attorneys to handle appeals those programs may not be able to take.

2. With the lack of education across some of the most rural areas of NC, and more than likely the Ombudsman will be overloaded with advocacy requests, will there be an advocacy agency that can assist in the appeals process when and if it is ever needed?

   A: See previous answer.

3. Do you keep the same ombudsman once you start with one and going forward with other issues?

   A: In many cases yes, but in more complex cases the client may be transferred to a more experienced staff member.

4. What is the difference between the enrollment broker and the ombudsman?

   A: See slide 26 for what enrollment broker does and compare to slide 36 for what the ombudsman does. The enrollment broker enrolls and disenrolls. The ombudsman helps make sure the system works for beneficiaries so they can get the care they need.

5. Can I get the Ombudsman phone number one more time?

A: The number for the ombudsman is 877-201-3750 after April 15. For more information, see the ombudsman website, ncmedicaidombudsman.org.

6. Will providers and facilities be required to post Ombudsman contact info for members and residents?

   A: No, but they will be informed about the program in a provider bulletin soon.

7. What is the provider ombudsman versus the beneficiary ombudsman??

   A: These are two different programs. The program discussed here is for beneficiaries. The provider ombudsman helps providers with issues like enrolling in a plan, being credentialed, and getting paid. For provider ombudsman information, see this NC DHHS website.

V. Non-Categorized Questions

6. Consumers and Families are having difficulty finding the handbooks. Can you provide the links to each one or what website list the links?

   A: Each of the plans has their own members handbook. For example, WellCare's member handbook can be found here: Link to WellCare's Member Handbook. The links for other plans can be found here: Link to other plans. The notices and other information from the state can be found on the county playbook site: Link to County Playbook

7. Are these changes all happening in SC Medicaid also?

   A: This webinar and these changes are specific to NC Medicaid. SC Medicaid has a different managed care system.

8. Is there a required minimum medical loss ratio (MLR) that the medical plans must meet?

   A: Yes. The sample contract information for the plans describes the MLR and the process for calculating it. The NC DHHS transformation website regarding the health plans also includes the contract amendment and other information.

9. When Mecklenburg County piloted mandated Medicaid enrollment in HMOs (1996-~2001), the HMOs left the market or merged creating great churn in plans, not enrollees. Is there a guarantee that the for-profit plans must remain in the Medicaid market?

   A: No. However, the plans have signed contracts and seem committed.

10. How would you describe the differences between Medicaid Direct and Medicaid Managed Care, from a Member perspective?

A: The main differences are a more limited provider network under managed care and there are also changes in who must approve a request for services.

11. How will care managers differ from care coordinators?

    A: Care managers do more than care coordinators and are housed locally in provider offices rather than centrally with the plan.

12. What is the definition for eligible Human Service Organizations for the Healthy Opportunities Pilots?

    A: For more information on the Healthy Opportunities Pilots, see https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots/healthy-0

13. Can you discuss the new approach to payment that is replacing fee-for-service?

    A: The plans get a capitated (flat) amount per enrollee per month from the state versus the current fee for service system. In the future, “value-based” payment incentives to providers will be added.

14. If someone is on SSI, can they apply for Medicaid benefits?

    A: Persons on SSI automatically are enrolled in Medicaid.

15. How is the minor's consent for treatment being explained to the minor's with decision capacity by the PHPs? Or is it just up to the primary care provider to do this?

    A: This is a provider responsibility.

16. With the new Medicaid managed care will they have the right to appeal their discharge from a hospital, like Medicare members are given the "Important Message from Medicare?"

    A: Managed care does not change hospital discharge rules.

17. What was the Section in N.C.G.S. 108? Thanks again!

    A: North Carolina General Statute 108-D is the chapter of the General Statutes governing Medicaid managed care in NC, along with federal Medicaid managed care regulations. G.S. 108D is worth reading by everyone concerned and should help answer questions.

18. Is there a link where I can find the difference between straight Medicaid versus Managed care?

    A: DHHS has numerous resources at https://medicaid.ncdhhs.gov/transformation.

19. What was the Section in N.C.G.S. 108 for disenrollment causes allowed?

    A: N.C. General Statute 108D-5.3

20. Will there be a glossary for all of the acronyms being used?

    A: We attempted to spell them out the first time they were used in the slides and in this Q&A.

21. If we e-mailed questions previously, will those be addressed?

    A: They should be included here.

22. Do providers need to now contract individually with each PHP?

    A: Yes, a provider needs to contract individually with all PHPs if it wants to provide services to individuals enrolled in that plan.

23. When are the standard plans (e.g., BCBS, Amerihealth, UHC, Carolina Complete Health, and Wellcare) required to provide resources/information regarding authorizations/logins?

    A: This is a question for the provider ombudsman.

24. Are non-hospital medical detox services related to inorganic detoxes like heavy metals, or just narcotics detox?

    A: We do not have information on this.

25. How will providers be paid in lieu of the fee-for-service model?

    A: Providers need to negotiate rates with each plan when they enroll.

26. Will there be additional webinars on claims submissions, credentialing, portal access, etc for providers?

    A: DHHS is doing a number of webinars for providers.

27. Once this recording is released, can we share it with our networks?

    A: Yes.

28. Will Medicaid reform be affected if NC decides to take advantage of the ARPA funds to expand Medicaid?

    A: Unless the general assembly decides otherwise, the expansion group would be enrolled in managed care plans.

29. Will we continue to bill Medicaid for all claims through a clearinghouse or will we have basic Medicaid plus the other 5 payers?

    A: The latter.

30. Under the new plans is it necessary for the provider to get preauthorization for behavioral health services? Also how many behavioral health visits are the patients allowed per calendar year?

    A: This varies by service and by plan.

31. Do PHP contracts require documentation for every patient-provider contact providing data about the reason for visit/diagnosis and intervention/treatment? What enforcement measures are included?

    A: We do not have information on this at this time.

32. What does expedited follow-up by PHPs mean in terms of how quickly is the follow-up for high-need individuals that were cared for by MCOs?

    A: That is not specified to our knowledge.

33. I would like to know if you have any employment opportunities for CHW certification

    A: Check websites of sponsors.

34. Will there be any ONLY behavioral health training?

    A: We are planning follow up webinars and that is a likely topic for one.