

North Carolina Justice Center
NC Medicaid's Move to Managed Care
Monday, June 3, 2019
2:00 p.m. – 3:30 p.m.
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[The webinar will begin shortly. Please remain on the line.]

>> The broadcast is now starting. All attendees are in "listen-only" mode.

>> Good afternoon, everyone and welcome to today's webinar. NC Medicaid's Move to Managed Care: What Health Care Advocates Need to Know. Presented by North Carolina Justice Center, Disability Rights North Carolina and National Health Law Program and Charlotte Center for Legal Advocacy. I'm Brendan Riley, NC Justice Center and I'll be moderating this webinar. Today joining me is Elizabeth Edwards, National Health Law Program, Meisha Evans, Disability Rights NC. And Doug Sea, Charlotte Center for Legal Advocacy.

Before we discuss today's agenda, let's cover a few housekeeping and logistical items. We're using GoToWebinar for today's presentation. You can use your computer speaker or your telephone to connect to the audio portion of the today's webcast. All audience members are in "listen-only" mode. Many of you submitted questions ahead of time when you registered, and we try to incorporate relevant information from your questions into today's presentation.

While you are muted, you can submit questions throughout the webinar, and we encourage you to do so. You have to use the GoToWebinar questions pane which is on the right-hand side of the screen. Please feel free to submit questions at any time. But we will only be answering your questions during the Q&A period at the end of the webinar presentation.

So we reserve the first hour of this presentation to go through all of our slides, and we saved the last half hour or so to make sure we get to your questions. So feel free to send them throughout, but you can also ask questions at the end when we open things up for questions.

Also at the end, we will have a short evaluation survey that we'll ask you to fill you the once things wrap-up. It takes 2 minutes, but you can share what you liked about today's web March and what other topics you might like in the future and generally give us feedback. So please do that when you wrap things up.

After the webinar, we will make all webinar materials available. Including the slides, a recording of the webinar, and transcription. And some of these materials are available today as handouts, which you can download in your GoToWebinar pane. You should find them right below the questions pane on your right-hand column for GoToWebinar. The handouts you should have there will include a copy of the slides, two fact sheets from North Carolina Medicaid, which includes an overview of Medicaid managed care, as well as a fact sheet of enrollment timelines, and there's also a new public and beneficiary facing fact sheet from many

of our organizations as well as NC child legal aid of North Carolina and physical legal services. And that fact sheet focuses on the changes coming to Medicaid. You can download and save these materials or handouts at any time during the webinar.

Also, closed-captions are available for today's webinar. The link on your screen here is also available in the chat box in your GoToWebinar pane. It's the first message you saw pop up as soon as you joined the webinar. This link will open a separate page in a new window, which you can resize and move so you can watch both the captions and webinar simultaneously.

Today, we have a large and diverse group of people on the webinar we're excited about. This group includes many healthcare providers. Today's webinar is going provide an overview and also deeper dive of some of the pertinent issues for Medicaid beneficiaries and advocates. We're going to touch on a number of issues that are particularly relevant for providers. But we're not going to go in-depth on a few, such as provider payments, contracts, care management, and other issues. For more information on those issues, we will refer you to a series of trainings conducted and recorded by the state. We'll have a slide on a few of these topics that we'll go over briefly. But we are going to focus on topics that are particularly relevant for beneficiaries and their advocates.

All right, so let's do a quick review of the agenda.

Today, our presenters are going to discuss the following issues. We're going to do a quick background on North Carolina Medicaid transformation, and we're going to dive into enrollment timelines, expected issues, who's eligible, who's in and who's out. We'll also cover changes to services coverage and as well as administration. We're going to deep into beneficiary rights and protections, some of the anticipated issues and problems we need to watch out for. And also discuss how you can get help for beneficiaries. After that, like I said earlier, we'll take your questions and do answers after for about 20 to 30 minutes after the end of the webinar. All right, so we've got a lot of material to cover. And we want to make sure we have plenty of time to answer your questions. So I'm going to go ahead and get things started. And I'm going to turn it over to Elizabeth Edwards, National Health Law Program. Elizabeth, your line is now opened.

>> ELIZABETH EDWARDS: Thank you, Brendan. And just for everybody's information, some of the slides that we have will go through fairly quickly. But we are trying to make sure we have plenty of time reserved for the end. So if I go through this fairly fast, just know that we'll have time for questions at the end. So, quickly, we're going to go over the backbone of why we're changing to managed care, and what exactly is happening, and the general timeline.

So, in general, managed care as it exists now is a fee-for-service program, so it simply is an entitlement program and provides health insurance to many low-income populations. And we're talking about more than two million people in North Carolina, with additional over 100,000 children covered by North Carolina health choice, or CHIP. And like I said, currently, Medicaid operates as a fee-for-service system where the state simply pays the providers when they provide the service. And currently, we have community care of North Carolina, CCNC helping to coordinate the care for typical healthcare services. And we have the local news that is LME, MCO is managing the payroll healthcare. So it's not that we don't have managed care in North Carolina, but we are moving towards comprehensive managed care.

So like I said, we do have some existing managed care in North Carolina through the LME,/MCOs. And they really manage care for mental health, developmental disabilities, and substance use disorder services, that includes innovation waiver as well the B3 services. And

manage care in this system for the LME, MCOs, they receive capitated payments and operate closed networks for providers. Capitated payment simply is the labor fees of per member, per month in payment. Currently, we have 7 L/MCOs operating within the state. And they will continue to operate for the next few years. And we'll talk more about that later.

So transformation. We've been hearing about this for a while now. It has been started in 2015 with the general assembly directing DHHS to change North Carolina's current fee-for-service Medicaid structure to a managed care one. So that is taking LME/MCOs and adding more managed care to the program. With only changes from Medicaid is delivered, it's just not all change who is eligible for the program. So some of you may remember when DHHS submitted the 1115 waiver to CMS in 2016, there were some mention of an expanded Medicaid population. That is actually not part transformation program. So in 2016, the waiver was submitted, and it was amended in 2017 after sort of a listen session round by DHHS. And it was approved in November 2018. And since then, we have set out RFPs and awarded contracts for the plan, commercial plans for managed care. And phase roll out is plan to begin in July of 2019.

So what are we talking about Medicaid transformation? The bill from the legislature directed the state to move towards an integrated care model. Which is supposed to be where a person's physical healthcare and behavior healthcare is treated sort of as a whole person and addressing both medical and non-medical drivers of health. So part of North Carolina's system is to include what we're calling healthy opportunities pilots to address social determinants of health. And other features. Program includes ombudsman program, beneficiaries, provider support, that is a bit more than the critical managed care and some other features. Generally, there are different provider networks about plan. So in our state, standard plans must be willing to accept any willing providers until their plans can still have closed networks for behavioral network services.

The managed care for Medicaid is very much like typical private healthcare where there's a network of providers. The other big change for managed care is that the appeals process, you now must exhaust at the plan level, plan of appeal before you get a hearing. And in the big change for beneficiaries is that they're going to now have to choose a health plan for most of our beneficiaries. And then in a moment, we'll help them with that.

And that means they may not be able to get all their providers in the same health plan. But important thing to remember about Medicaid transformation, there's some things not changing under the whole system change. Big thing is the eligibility rules and the eligibility profits for Medicaid are not changing. Neither are the coverage services. From new services will we added. So, for instance, some of the social determinants of health services will be added over time. How services are authorized and delivered and presented to populations will not change either. The waiver waitlist will not change such as innovations waiver or CAP/C or CAP/DA waivers will not change. And CHIP eligibility will not change over the CHIP beneficiaries must enroll unless they are exempt.

So what does the structure look like for us? The legislation required DHHS to contract with four statewide pre-paid health plans. You'll hear the term pre-paid health plan as PHP, where we use the plan or standard plans, sort of all the similar things. Legislature requires up to 12 regional plans to cover up top 6 regions. And those plans could either be commercial plans such as commercial HMOs or Provider Led Entities, which would be controlled by North Carolina providers. And also the LME/MCOs will continue to serve and exist PHP for tailored plans for specific populations. Other than the new transformation system, we will have two

types of health plans. There will be standard plans, which will include most Medicaid enrollees, including those with mild to moderate behavioral health problems. And then we will have tailored plan for people with serious mental health or substance use disorder needs, intellectual and developmental disabilities, or traumatic brain injury. These tailored plan will have a delayed launch until at least July 2021. But LME and MCOs will exist in the meantime.

So as we've said, standard plans exist across the regions. There are 6 regions as you can see by the map here. The statewide plans that are going to exist in managed care in North Carolina are Blue Cross Blue Shield, AmeriHealth Caritas, United Healthcare and WellCare. And in regions 3 and 5, there will be provider institute called Carolina Complete Health, which is a partnership of North Carolina Medical Society and North Carolina Community Healthcare Association along with Centene.

We did want to note an appeal has been filed by 3 successful bidders in the RFP process to be planned in North Carolina managed care and request to the judge to lay legislation is pending. And, so, some of the time we're going to talk about today are those appeals, if successful could get pushed out.

So what happens to our LME and MCOs? We're going to discuss this very briefly. The bill will continue in terms of July 2021. To managed care for MH/DD/SA, but only for those with serious conditions. And we'll talk about that more in the next slide. So physical healthcare for this population will continues to go through fee-for-service. So they will not enter into the commercial plans unless some people want to. We'll find out more about that as well.

Beginning of July 2021, those LMEs will become tailored plan and manage both MH/DD/SA services for those individuals as well as physical healthcare. And, yet, again, the people with tailored plan will only be those with severe behavioral health conditions.

The one thing to note is there are still only the one-tailed tail per region. So that current system is operated at a region and you cannot have other choices will continue at least until 2025.

So, eligibility for tailored plans, we talked about those only being for limited people. It's set up to include individuals with serious emotional disturbance or diagnosed with severe substance use disorder, or TBI, or developmental disabilities, as defined in the statute. Or serious mental health conditions as defined by the 2012 settlement agreement with DOJ, including those in the community living initiative settlement.

And other way people can be part of a tailored plan are identified as being in a tailored plan will be use of services. So this includes individuals who with 2 or more psychiatric hospitalizations or readmissions within prior 18 months, or with 2 or more visits to the emergency or psychiatric problems in the past 18 months, or those who have been involuntarily treated within prior 18 months. So they're all very much based on the services you've gotten in the past and your condition.

So enrollment. This is sort of the next big thing that's going to be happening for individuals moving into managed care. The transition timeline, DHHS came out with a graphic that is pretty helpful to understand how this works in the past within a month or so. And as you can see, the enrollment packets are supposed to start getting mailed just at the end of this month. The open-enrollment which is when people can pick a plan with the help of the enrollment broker which is Maximus in the state. They can pick the plan through most of December. And then if they do not pick a plan, they will be enrolled. And their health plans with effective date will be November 1. And then in the other regions, so being Phase I and Phase II, in the second set of regions, that enrollment will start in September with open-enrollment going through most

of the end of the year until 12/13 2019 with a health plan effective date of February 1, 2020. And as I've said, it's separated by regions as you can see in the map to the right as well.

So, as I've said, enrollment, under enrollment, individuals will be given a choice of plans. And there is an enrollment broker which is run by Maximus of North Carolina to help Medicaid recipients select plans. And this should help them understand which plans have which providers and their networks and other sort of important choices to individuals. You have 60 days to select a plan and the primary care physician. And PHP will be auto assigned by enrollment broker based on specific criteria. So individuals Who have 90 days can change their plans for any reason, with no cause. Just enrollment and reenrollment are those exempt and can disenroll at any time, because their enrollment is voluntary.

So members can also disenroll for cause at additional times, but for cause disenrollment is limited to specific sets of reasons. And, so, they can disenroll and then if they are denied the enrollment, they will have the ability to appeal that decision.

There will also be choice of providers within the plan. So each member will have a choice of their Advanced Medical Home or primary care physician. If they do not choose a medical home, they will be auto assigned by the plan. And that's for PHP. And the member can change their AMH/PCP without cause twice per year and more often if for cause, they must contact the plan to change their primary care physician.

So we've been talking a little bit about who must enroll and who is exempt, and there's delays. And I bet this is quite confusing. However, hopefully this chart will help. So, those who are in, it's going to be almost all of the Medicaid participants, unless they fit into an excluded category. There are two groups of people who can enroll in managed care if they choose to, but they do not have to. They can stay in fee-for-service if they want to. So those who can go to managed care are not included eastern band of Cherokee Indians. And those beneficiaries with serious intellectual or mental disabilities, or mental health diagnoses. So those people who are kind of currently served by the LME/MCOs and meet the criteria for tailored plan.

So who is out and excluded? There's a list here on this slide. I wanted to highlight quickly CAP/C, CAP/DA, people who have family planning Medicaid, nursing facility residents, and children in foster care. So children in foster care are delayed. They're expected to delay into managed care later.

So, enrollment plans can be confusing with bunch of dates going on. There's bunch of population going in and out. And some people are optionally enrolled in managed care. They can go in if they want to. So that has created a bit of confusion. So state is relying on data matches to determine who must enroll. Unfortunately, the state doesn't have data on those new to Medicaid or new to North Carolina. So the enrollment broker will have a higher duty there to make sure that those people understand what's going on. But that might not work out quite perfectly as they expected. It's something that we're concerned about. The state also has limited data on other groups such as those age 0 to 3. And in terms of what kind of services they use and who is their primary care physician. And also state data may be out-of-date or incorrect. And state will also rely on beneficiaries not I.D.'ed by the data match to "Raise their hand" to self-identify as exempt from an enrollment.

So, for example, if a person uses some degree of mental health services, but it's not clear where they belong, whether or not they're exempt, and you might go to choose a plan, or they're going into commercial plan, their going to be in that "Raise your hand" group to say I should be exempt and I don't want to be in managed care yet.

They will be able to request, if they identified as being in managed care, they will be able to request in writing they disenrolled and be able to appeal that. The state will also rely on the providers to help request exemptions. And, so, there's bit of few who might be lost in the middle. Even for those state identified as exempt, the state might send confusing letters to encourage you to enroll in managed care standard plans. So, be on the lookout for that.

And those with mental health and developmental disabilities, the substance use disorder, who are enrolled in standard plans, they may not be able to get all the services they need until after they have successfully disenrolled. And, so, they can go back to the LME/MCOs for those services.

So, what do affected beneficiaries need to do now? Make sure that the DSS has their current mailing address, phone number and email address so they receive all notices about any changes, list managed care that's specific to them. And also make sure that in late June 2019, or later, depending upon which region they live in, they need to start looking for a letter telling them to enroll in the health plan. And to contact the enrollment broker and ask if they're exempt. And if not exempt, they will have to ask enrollment broker to help choose the plan or the doctor.

And really quickly kind of what to know here is that if you're talking to somebody, either a provider or an advocate who uses LME/MCO now or has in the immediate past or may need to in the future, they might be in that exempt population. And they might be better served in an LME/MCO or in standard plan. It really is dependent on what services they need. And, so, maybe watch out for those people and make sure they understand what's going on and what their options are. And also if Meisha an exempt, other exempt populations.

So, I'm going turn it over now to Meisha to talk about services changes and what is going to happen under Transformation to services.

>> MEISHA EVANS: Thank you, Elizabeth. And there is some spontaneous landscaping going on on our end, so if you start to hear something roaring in the background, I'll just speak up louder. Just let me know. So service changes. It's important to understand that North Carolina's move to Medicaid managed care is a change in how Medicaid is delivered. It's not a change in services. Under Medicaid managed care, pre-paid health plans will be required to cover all the same services they cover now under the fee-for-service model.

So if a service is covered under Medicaid fee-for-service, it will also be covered under Medicaid managed care, because, again, the overall structure isn't -- excuse me, the overall funding mechanism isn't changing. Excuse me, it's not structure that's changing overall as far as the delivery service and who's eligible. It's just the funding mechanism.

So we want you to note here that PHPs will now be required, now be responsible for non-emergency transportation. PHPs will be required to assist with arranging non-emergency transportation for its members. However, DSS will remain responsible for transportation for population that are not moving to Medicaid managed care. So any population that Elizabeth referenced before will stay in fee-for-service. Those populations will continue to have their transportation managed by DSS.

So PHPs may not require referral or prior authorization for emergency services. Family planning, direct access to women's health specialist, children screening services, or to first mental health or substance use assessment within the first 12 months.

So, again, that echoes services are not changing, just the structure.

We like you to note that certain services will remain carved out of Medicaid managed care, meaning they will not be moving to the new model. They will remain in fee-for-service. So Dental services, eyeglasses, services that are provided by local education agencies, and

services provided by children's developmental services agencies. Those services are all carved out.

And, finally, we want to note that PHPs must have a system to review drug utilization and drug interactions. Any correct doses, appropriate use of generic and also screen for opioid misuse. So that will continue under Medicaid managed care.

So now we will talk about the service group that will be offered under standard plan and the services that will be offered under tailored plan. This slide is a great tool for beneficiaries to use in order to compare what services they can expect to see. And standard plans, what services they can expect to see under tailored plan. The services on the left are everything that you can have tailored plan to provide. Excuse me, a standard plan to provide. And the services on the right are tailored planned services. Now, the tailored plans will provide all the standard plan and services in addition to what you see on the right-hand column.

Standard plans will also cover some enhanced behavioral health services such as mobile, crisis management, substance use disorder and outpatient programs, psychosocial rehabilitation, and EPSDT, and diagnostic assessment.

And now we will move forward to talk about network adequacy.

So, PHPs are required to contract with essential providers. And an essential provider is defined by the enabling legislation for Medicaid transformation. They are federally qualified health centers, rural health clinics, rural health centers overseen by the DHHS. Free and shoppable clinics, state and Veterans home and local health department. Those are all considered essential providers. So, one of the roles of the PHP is to make sure that the beneficiaries are receiving the types of services that meet their needs no matter where they are as far as ability, or culture, or background. So PHPs must use resources to help providers provide services in a culturally competent manner, and they must ensure that network providers provides physical access, reasonable accommodation, and accessible equipment to people with disabilities.

Another requirement for the PHPs is maintaining a provider directory. The provider directory has to be updated at least monthly. It must include the provider's name, the group affiliation, the location, the county they serve, their website, which specialty that they have providers for, as well as whether they have any type of linguistic capabilities, and whether or not they have any cultural competency training, and, of course, the phone number where the beneficiaries can reach them.

And then one final thing to note for providers who are applying to be with them in PHPs and attachment area, DHHS will establish a centralized credentialing process that will include a standard provider enrollment application and qualification verification process. And goal with that is to make sure that providers aren't overburdened with paperwork trying to network with all of the PHPs that we have.

So now we will move to discuss care management. The DHHS estimates 100% of enrollees will have access to care coordination. And about 22% of enrollees in the standard plan will have needs that require – 100% will have access to care coordination, and then about 22% of the enrollees of a standard plan will have higher needs that require care management. Care coordinators are expected to perform tasks such as conducting care needs, screening, providing links to community resources, and also given the higher member to staff ratio that these PHPs will have, we expect that care coordination will be an important role for the PHP to fulfill, by not only discussing what the best way to provide services with stakeholders, but also, you know, using a resource such as the statewide resource guide that I will reference in just the next slide which is called North Carolina 360. And also making sure that when they refer beneficiaries to

services, the care coordinators, that they're closing the loop and making sure the referrals just don't go up and end it. And the beneficiaries aren't just given a number and sent on their way.

So, under care management entity is an entity with which the PHP contracts to provide care management or care coordination services. And the entities that could be included as a care management entity include Advanced Medical Home, local health departments, and other contracted entities. And then the priority population that DHHS expects to see for care management include individuals who require long-term support and services. Adults and children with special healthcare needs. Individuals who are identified by the PHP as being high-risk. And individuals with unmet needs. So those will be people who are homeless, who experience domestic violence, who fear for their safety, or who have other unmet needs, which I will mention when we discuss the healthy opportunity pilot. And the care management is provided for high-risk pregnancy population and also at-risk children from ages 0 to 5.

And, so, if Advanced Medical Home or other entities doesn't meet the care management responsibilities, or if they fail to meet the quality standard, a PHP can seek permission from the department to terminate the contract with that entity. And then they're no longer required to pay the care management fee. And, so, that's just one of the many checks and balances which I'll touch on in a bit. DHHS has included as they move onto Medicaid managed care to make sure quality services are provided and that there's oversight.

So now we'll discuss the healthy opportunities pilots. The healthy opportunities pilot is to address the non-medical factors that drive on health outcomes and costs such as unstable housing, insufficient food, lack of transportation, and interpersonal violence. If an unmet need is identified, the PHP is expected to connect the beneficiary to community resources, and if it's a high needs case, to provide more support as needed. So I've mentioned North Carolina Care 360. North Carolina Care 360 is an effort that launched in January of this year. It is a statewide tool to connect individuals in need with their community resources. So typically what we see now is that resources in the community are very fragmented, and if populations, and people in need can't get care across the state as they should. So a tool that we will have as North Carolina Care 360. And this is really part of the department no-wrong-door approach. So this implementation started in January of 2019 and the department expects North Carolina Care 360 to be available in every North Carolina by end of 2020. So in addition to statewide efforts and statewide region in North Carolina and select regions of North Carolina, PHPs will work with community-based, health and human resource organizations to launch healthy opportunity pilots. So the regions will be a mix of urban and rural counties. And we expect the pilot to launch in early 2021. So that's, again, the healthy opportunity pilots are meant to address the unmet non-medical needs of beneficiaries may face and often the barriers to healthcare. And the target populations includes children and adults with chronic conditions who are homeless or at-risk of homelessness, who are food insecure, who may have issues with toxic stress. And this includes women with complex social needs, excuse me, pregnant women with complex social needs, and adults who have repeated avoidable use of emergency department and hospitalization.

So, in the next 3 slides, we're going move towards provider payment. The next 3 slides have to do with provider payment. But in the interest of time, I'm going to allow you all to review that section on your own. At the end of the presentation, as Brendan mentioned, there is a link to the department's very in-depth provider webinar. Okay, so monitoring and over sites. There's number of systems in place to ensure PHPs properly provide quality service to North Carolina Medicaid beneficiaries. On the front-end, PHP must engage with different stakeholders, such as community and county organizations. The enrollment broker, the local DSS and

ombudsman Programs, and they're addressing certain issues. All of that input, make sure that issues that PHP may not see from their perspective if another, you know, stakeholder and system sees it, that information will be shared and the solution can be found.

Additionally, PHPs must have compliance plans. Methods to prevent, detect, and report fraud. And they also must have procedures to recover cost from third-parties when there's third-party liabilities.

So now I will go ahead and turn the presentation over to Doug and he will walk you through it.

>> DOUG SEA: Thank you, Meisha. We're now going to talk at some length about beneficiary protections that are built into the plan. And some of the issues that we executive to see for beneficiaries and their need for advocacy. I want to start by mentioning that we just mentioned previously that there will be a beneficiary ombudsman. In fact, the RFP for that just came out, which we're very pleased about. However, there's going to be a delay before that ombudsman can get off the ground, probably some time in November it looks like.

And if the stay is not granted by the judge in these appeals we mentioned earlier, then, again, a lot of people will have already gone through the period of having to enroll in managed care without there being an ombudsman. And the enrollment broker will be available to those folks at that time, but if there are problems during that initial roll out, it's really going to be up to other advocates, especially, before that ombudsman is in place.

So let's jump into the specifics here. Week expect there to be a lot of confusion. I'll bet there's confusion from people on this call, because it's a very complex process. And there's going to be a lot of transitions between people who go into fee-for-service, people who go out of fee-for-service. Just one example. People who have MediCare are not exempt from managed care. Well, if you get MediCare, if you become MediCare eligible while you are enrolled in managed care, you should be immediately transitioned out of managed care. But will that happen?

Another example is people who are new to the state or new to Medicaid. They actually are exempt, they may be exempt from managed care, but the state has no data on them. And they're going to rely, as we mentioned earlier on this, raise your hand process, which turns out is like a 15 page form that this person is supposed to complete with all kinds of documentation attached to it to prove that they are exempt from managed care, that they need these enhanced mental health services. And this is a population that, of course, is very ill-equipped to raise their hands because of their in a mental health crisis. Meanwhile, they may not get the services they need.

We also fear there's issues and the department is concerned about not having correct addresses for everybody that DHHS has not updating everybody's addresses, because they just don't touch the file often enough. So people may not even get their enrollment packet. They may end up auto assigned into managed care. And then into a plan and to a provider that they don't know about until they show up. So they show up, and all of a sudden, they do not have and told I'm not your doctor anymore.

And then, will they get the assistance they need? We hope so from the enrollment program. But if they don't know about the enrollment broker or can't get through the phone or the broker doesn't have good data. For example, broker is supposed to have all the directory from the plan who their providers are. But will the provider directory be there in time and be up-to-date and a lot of providers are not enrolled in these plans and they're going to be constantly

changing. Or will it say if the provider is not taking new patients or new Medicaid patients, probably not.

So they may think that their provider is in the network, but in practice, it may not happen. Also the issue of inadequate provider network is a big concern. Because, you know, we already see that with LME and MCOs, and we're going to see that with other Medicaid services as well where a lot of providers are not enrolled with the plan because they don't like the rate being paid or they don't want to contract with all these different plans, then we worry about people having timely access to care.

On paper, the time and the distance standards, the appointment wait times, and the network adequacy rules are excellent, but will the plan meet those and if not, will that be enforced by the state? Those are the concerns we have.

Obviously, we're concerned about inadequate and improper denial of services, and in some cases, services may get denied without written notice. We're very concerned about the confusion about Medicaid transportation. People are used to getting it from DSS. All of a sudden, they have to get it from the plan. With the plans have transportation networks set up? And will they be adequate? Do the plans understand EPSDT and these are so many things we don't know yet about the plans and many of them come from out of state and do not all have great track records in other states to be perfectly honest. So there are real honest to be concerned as people shift into this new system.

Remember, we've never had managed care except for the LME and MCO in North Carolina. So this is a completely new phenomenon for these almost two million Medicaid recipients who have to learn about this new complex system. And then make successful transitions from one system to the other, and then maybe back to the first one as their situation changes.

Next slide. So, obviously, for now, the most important thing is that beneficiaries need to know to choose a health plan and doctor, unless you are exempt. Because otherwise, you will be auto assigned. But there are luckily rules in changing the doctors and plans. So if you're not satisfied, ask to change. The eligibility is not going to change. Medicaid should continue to cover the same services. And I say "Should" because again, we have to see whether that happens in reality. We know on paper that's supposed to happen. And we know that the clinical coverage policies that the state has of plans are supposed to follow those. They're not supposed to make up their own rules about who gets services. But will they actually do that?

And, then of course you have to see in network providers, but there are exceptions to that rule. If you cannot, if they can't provide an in network provider in a timely manner that's a reasonable distance from your house, and that is the specialty provider you need, then they have to cover out-of-network provider that you request. But will that happen? And will they tell you that? And will they assist in finding that provider? Those are the questions that we have concerns about.

And, again, if you need enhanced services, you can be in the middle of mental health crisis. If you're in a standard plan, all of a sudden, you need services that you can't get until you successfully disenroll, and will they get help in doing that? The help they need in doing than? Next slide.

So, there are important rights that beneficiaries have. They have the right to free advice from the enrollment broker. They have the right to switch plans. As we've said, 90 days for any reason, good cause or rest of the year, they can request to disenroll from a plan or disenroll from managed care. And they can appeal if that request is denied. And that appeal process, by the

way, there is no internal plan step for that appeal. It goes straight to the administrative hearing just like fee-for-service appeal do now.

They, again, I mentioned out-of-network care. The right to have your care not interrupted if you transition. And, of course, the right to appeal if the plan denies, reduces, or partially approves, or stops coverage for needed care.

So, there is two things that people get confused about in an appeal versus a grievance. This is generally to appeal a benefit to determination. That is a denial reduction or partial approval, or a termination of services. A request for services generally.

And that, you have 60 days to ask for that appeal. You can ask for it orally, but you have to follow-up in writing. There are good cause exceptions. Then you have to exhaust this internal appeal process. They're supposed to bring in someone different to hear that. You can ask for an expedited appeal. And then of course, if you fail in the internal appeal process, you go on, and you can then ask for a state appeal within 120 days before the office of administrative hearing. Just like you can now.

Next slide.

So, notice the timeframe have increased for fee-for-service, it's a shorter time. You only have 30 days to ask for that OAH appeal. So a grievance is different. A grievance is you're complaining about something else. Like you don't have actual access. I can't get to reach my care manager. I'm not getting the language access I need or the disability accommodation I need. My provider is not showing up, et cetera. It's just a whole range of any other problems you can file a grievance with the plan about that. Of course, there are no real appeal rights if they deny your grievance or don't take any, you know, don't give you any relief from your grievance. And that's where I think the ombudsman is going to be so important, because that's really the ombudsman's job is going to be to help people resolve problems without having to go through an appeal process. But we'll see, you know, how soon they can get that going.

Next slide, obviously, this is the technical definition of that adverse benefit determination that is appealable. But as I've mentioned, the main thing is if you are denying, reducing, or partial AI proving services or if you approved the request but for a shorter period of time than what was requested, that is also appealable. And, of course, if they don't act on your appeal in a timely manner, then you can go straight to OAH. So that's why that's in there as well. And if they don't provide services in a timely manner, that is also an appealable action.

So, now, continued benefits. They have to continue benefits with timely appeal. But only if it involves a termination before the end of the authorization period. So if you're authorized for the service for 6 months, and at the end of the 6 months, you request reauthorization, I need it for longer, I need it to keep my service for longer than 6 months, and they deny it, that under managed care regulations is not considered a termination. It's considered a denial. So there's no right to continue services pending appeal. It's only if they reduce or stop your services during the authorization period.

Next slide.

So, there are other protections. The marketing materials have to be approved by the state. They can't do direct solicitation, door-to-door, by telephone, please join our plan, we have the best plan. Again, they have to provide all these services for people with disabilities and Limited English Proficiency. They have to operate a member service line, behavioral health service line, a nurse line. They of course have to follow the estate procedure, grievance procedure, and, in fact, the state is going to be telling them what forms to use, what the notices

look like, what enclosure that goes with those notices look like, how they're pre-populated. All of that information will be dictated by the state.

I know that, because we've been working with them to do just that. And they also will be establishing a member Advisory Committee and long-term services committee, and they're supposed to facilitate transfers when appropriate. And that's a critical element I believe.

So here's some issues to watch for. I've alluded to some of these, but let's just run through this list. And I encourage you to keep this list as a checklist when you're talking to your clients about their experience with managed care and to help us know what's going on out there. So enrollment issues. Are they exempt from having to enroll? Are they required to enroll any way? Were they told they can disenroll? If they do request disenroll, was that decision made in writing and with appeal rights? Were they given misleading or aggressive marketing practices subordinated to that? I am sure the provider directory accurate? Are the providers listed really accepting new patients?

Next slide.

So, were they given a choice of plans before being auto enrolled? Was the enrollment broker helpful and successful in choosing a plan? And how about requesting an exemption or explaining to people who has to enroll and who doesn't have to enroll to help them change plans?

Were they permitted to change the plan after 90 days and did they have good cause and did the plan explain that process? And was a request to change plans acted on? Was the decision in writing or appeal rights if that is denied?

So if their mental health conditions worsen and now they need enhanced mental health services, was beneficiary smoothly transitioned to the standard plan LME without interruption in care or delay in getting the needed services?

B3 services or state funded services. The only way they will be able to get those is through the LME or through the tailored plan.

If they started getting MediCare, I mentioned that. They got into the CAP/DA or CAP/C program, were they promptly disenrolled for managed care? They have to be, but is it going to happen quickly? Is it going work the other way where plans actually try to disenroll or encourage people to leave their plan if they're costing them too much money? Or if they are just making too many complaints or grievances? Because that is another, obviously, they have a financial reason to do that. And, so, we have to monitor that closely that that kind of inappropriate behavior doesn't go on.

If they leave managed care, do the previously approved services continue without interruption? Or if they just change plans, but the provider is not in the new network, they're supposed to, the state has said that they are working to make sure that happens. We're still waiting on some of the details as to how that has happened. But the state is promising they will be able to continue with that same doctor provider for at least 90 days. Let's make sure that happens.

So, access to the assistance they need. Did you see the handbook and the beneficiary materials accurately describe their benefits, the rights and procedures, their appeal process? The state is providing a model handbook that the plans will be required to mail out to all of their enrollees. We've given input on that, but we haven't seen the final version yet. And, of course, whether the plans changed in some way, we'll have to watch that.

How to contact the ombudsman, that's going to be critical that that be included with materials. And it's going to be very challenging initially during this initial roll out, because we

don't know who the ombudsman is going to be. So, in the absence of that, are the materials going to say, well, here's how to contact legal aid?

Or Disability Rights. Or one of these other people who could possibly help you. So, to the plan and providers, do the plan and providers meet the 1557 requirement? To they provide services in a culturally competent way? And, again, the 1557 requirements are very strong on paper. And this applies to the providers, as well as the plans. Translators for materials in the person's preferred language. Tagline in 10 different languages. All the written materials in the person's preferred language, et cetera. But, you know, this is very challenging for providers and for plans. And, so, whether the people with those needs really have them met is something to pay close attention to.

Next slide.

So, were they allowed to change primary care physician when they needed to? At least once a year and more often if need, if they have a good reason. Do they need an Advanced Medical Home rather than just a regular personal primary care physician?

Is that PCP providing quality care management or care coordination at least. And remember, it's supposed to be local care coordination, not at the plan level or somebody on a toll-free number. It's supposed to be face-to-face by somebody they meet with at their doctor's office or somewhere else like that. And is that really going to happen?

It's a wonderful concept, but we need to make sure the plans really do it. And given the rush, you know, the hurried start up here, we have some concerns whether it really will.

Will they have timely access? Like I said, within those time and distance standards and appointment time standards to get the treatment they need, including specialty care, in-home care, all the rest of it.

Did they tell them that they could request out-of-network care? Were they denied that when they had a good reason? Were they given the information about the transportation to medical appointments and it's free?

And were they given a denial with appeal rights in writing if that transportation is denied?

So does it cover everything under EPSDT services and do they follow the state's clinical rules and follow EPSDT rules?

Do they meet mental health parity requirements in the coverage policy and review that and provide a plan for that. Do they follow the state's definition of medical necessity? And do they meet all the EPSDT requirements? Outreach, informing, screening, covering if it's necessary to correct or ameliorate that child's condition. And even arranging for those services to happen rather than just saying, you go find your own provider. Those are requirements of EPSDT. But will the plans do it?

Does the plan actually discourage people from requesting services or give misinformation? Do they say, well, you can request that service, but the it will get denied. Or, no, we don't really cover that for people in your situation. Well, if they discourage the person from actually requesting the service, then the due process never gets triggered. They never get their notice of denial with the right to appeal. So this is sort of the first step of Due Process making sure they don't discourage people asking for services in the first place.

And then they make a decision on that promptly, that they issue it in writing, and this last bullet point we're concerned about, if they're covering long-term services do they set the authorization period for a long time that you have to keep asking over and over again even

though you have a chronic condition? Because there's language in the federal regulation now that prohibits that. Next slide.

So, does the plan provide written notice whenever care is denied? We talked about that. Is it on the state's approved form? With the writing disclosure and pre-populated the way they're supposed to be? And do they specify on the notice real detailed reason, and the real specific legal authority? Does it make clear how much is approved and how much is denied? Do they include the right to continue services if that applies? This last one is very important.

Is the envelope post marked the same day as the date on the notice? Because it is required to be. They have to actually make sure it goes into the hands of the post office on the date the notice is dated, because, again, the clock is running for the client. And that's why they've got to get it into the mail that day. Next one.

So, was it approved in a timely manner? If it was requested, was it -- I'm sorry, processed timely. I'm sorry, this is the appeal. Was it a timely process? Was it expedited appeal granted? By the way, if the provider writes on the form that the appeal, that an expedited appeal is necessary because of the person's health may be in danger or may be in endanger without expediting the appeal, the plan has to accept that. They can't refuse that in that situation. Will that actually happen?

Will they offer assistance to people who need it and how to file the appeal or fill out the form during the process? Will they give them or discourage them from asking for the appeals or encourage them to drop it? Will they allow it to be filed over the phone? Will they give you the entire file, their entire file, not just what they want to give you to review? Will they allow you to present your case in person? And will they make sure someone with appropriate credential who is independent decide that internal level of a policy?

And then you have the OAH appeal, which is on the next slide. So the issue here is you have 120 days. They have a certain amount of time to make it. They have to give you the correct information on how to ask for that appeal, which has to be in writing to OAH. And then they have to make the file available. And OAH is now trial court erred expedite the appeal if that is warranted.

And will they, again, warranted and request that appeal if that applies? So that ends my part of this. And I'm turning it over to Brendan.

>> BRENDAN RILEY: Thanks so much, Doug. Appreciate that overview. I know we're covering a lot of content, but I thought that was really great overview. Just briefly I'm going to cover a few quick things. Obviously, you all, as healthcare providers and service providers, as advocates, you all play a really importantly role across many different touch points that Medicaid beneficiaries are going to have with this system as it's changing. So there's a lot you can do. But in particular, obviously, spreading the word that are this transformation is coming. Helping your patients and clients to understand the Phase I and Phase II roll out. What the obligations are right now. . So of the things we covered earlier that Elizabeth and Doug covered. And make sure the address is up-to-date. And be ready to look for information in the mail from North Carolina Medicaid, and evenly from their pre-date health plan if they are going to enroll or auto assign and they're not exempt. And, of course, so much of the Medicaid transform making is about trying to add least ostensibly improve health and we're align payment systems and delivery systems with our population health goals. And it's so, so difficult to be having those conversations and we know there's hundreds of thousands of people who are uninsured and not in the system stuck in a coverage gap. While it's not the focus of today's

webinar, we hope you're asking to state legislator to close the gap and make this happen this year.

So, all right, if folks have questions or concerns, particularly beneficiaries, they should contact one of the following organizations for free legal advice and assistance. And I want to remind you all of the handout on the right-hand side of the webinar pane. That third one, the NC Medicaid transformation. This one. Well, it looks like it's loading. This is a one-pager that our organization and NC child and legal services put together to provide two pages of information about what we think the public and beneficiaries need to know, as well as who to call if they need free legal assistance. So we definitely recommend you download that and save it and feel free to share that with the public and others. We think it's really critical that we arm people with information that's not only useful, but the also something that's actionable if they need to take some sort of action.

As we alluded to earlier, there's a lot of other information. We know a lot of you on this webinar are healthcare providers and we're so glad you joined us today. There's other places you can get information. Obviously, you can't click on this link on the webinar, but you can download the slide deck in the handout Section and you can access this link. There's also a lot of policy details and other links where you can find out more information.

And from there, we're going to go ahead and jump into questions. And I know number of you are sending questions in on the line. I just want to remind you, you can still type in your questions and send them to us. So you can just enter in, click open that questions tab on the GoToWebinar pane. Type in your questions. And we'll review them and start answering your questions. So I'm going to go ahead and unmute the lines of my fellow panelist, Doug, Elizabeth, and Meisha, and we also have Lee from end help who can help us tag team the questions. So we appreciate you being here too, Lee.

So I'm going to go ahead and get us started and just ask a few questions we've gotten in already.

First, I want to start with, we're getting a lot of questions about patients living with intellectual and mental health disabilities. And how things will work during the transition period. So let's start with this one here. Meisha, I'm going to turn this to you. So this question we got says: How will someone not currently using IDD service of his change over to a tailored plan when they want to start receiving services?

>> MEISHA EVANS: So, if someone needs to use a tailored plan service when they're not currently on the tailored plan, when their provider tries to submit authorization for that service is when they will be moved over to the tailor planned service. And it's 48 hours that it will take between the PHP and the others standard and tailored plan to make the change. You won't be prevented but it will take about 48 hours for the service to start.

>> BRENDAN RILEY: Thank you, Meisha. All right. Another question that we got. I'm looking at this.

So, this one might be for you, Doug. Someone asked: How will families be able to see multiple providers across the state? And this one is important, even out of state? Can you discuss some of those processes, Doug, and barriers people might face?

>> DOUG SEA: It will not be easy. Of course, the general rule is you have to stay in network. And, of course, people who work with the LMEs and MCOs are used to this. In fact, those networks are really closed, at least the standard plans are going to be required to contract with any willing provider. So if your provider is willing to contract with the plan, then you have

a solution there in terms of assuming they can agree on the rate. It's just have them contract with the plan.

But if you do need an out-of-network provider, you're going to have to show that there is not an in-network provider who is appropriate, and who is actually available to provide that service to you. And then you're going to have to make a specific request for that coverage of that out-of-network provider. And then of course, it may get denied. They may say, oh, no, our in network services are just fine. If then you're going to have an appeal on your hands.

>> BRENDAN RILEY: Thank you, Doug. All right. We have number of questions coming in. So those of you on the line, still feel free to send in question and we'll keep asking them and answering them. We still have plenty of time to answer your questions.

Another one here that I guess I'll ask you, Doug. This is with respect to Phase I and Phase II regions. This person asked: Will the enrollment date, or perhaps the launch date, is that based on the residency county of the beneficiary or the county in which the Medicaid application approval was done?

>> DOUG SEA: Those should in the majority of cases be the same. But you're right. There are some cases where people are receiving services out of their county. Now, a lot of those folks are exempt from managed care anyway. So I'm sorry. Maybe somebody else knows, which I haven't seen them make that distinction between the two, in terms of if you're not living in the county that actually is the one covering your Medicaid. I assume they're going to start with the county where you get your Medicaid and you have to request if you want to change regions for some reason.

>> BRENDAN RILEY: I don't have anything to add. So I'm take another question. I'll maybe have Elizabeth take this one. Elizabeth, can you tell you also about the ombudsman. One specific question was, will there be just one ombudsman? Could you talk about the program and what we expect it to do?

>> ELIZABETH EDWARDS: Sure, the RFP is issued just for one and designed this way for one ombudsman program. There is the expectation there will be some level of local contact to some degree for the ombudsman program. But there will be just one statewide ombudsman program that will operate sort of a centralized system to help beneficiaries. But they're in the RFP. And I haven't read the new RFP. But there's some expectation there's some degree of local, at least outreach and other kind of more localized opportunities for contact with them.

>> BRENDAN RILEY: Thanks, Elizabeth. Another question that I have, and maybe I'll put this to you, Meisha. It's a question that we got early on, which is how available will the enrollment broker be to members and in particular, this person means how available will they be in person? Not just by phone or online?

>> MEISHA EVANS: That's a great question, Brendan and maybe someone else, if I'm incorrect can, Doug or Elizabeth can correct me. But there will be a 24-hour enrollment broker line they can report to with issues or problems they're having. As far as in person, in some counties or enrollment broker will be in the actual DSS office. But that's not the case for every county. So if the enrollment broker doesn't have a presence in that county, then I'm not sure what the alternative will be as far as the in-person connection.

>> BRENDAN RILEY: Thanks, Meisha. Do you have anything to add to that Doug?

>> DOUG SEA: I think it's mostly the Call Center. They're supposed to be some outreach in different communities. But as far as I know, they still haven't started doing that. But

they're supposed to work with DSS and get information from DSS. But I'm not sure at this point whether that actual presence at DSS is actually going to happen at least initially.

>> BRENDAN RILEY: Thanks, guys. I appreciate those answers. We've got a few. Several other questions here. I might ask you this one, Doug. How long will it take for the change to take place when someone changes their Advanced Medical Home? So this is assuming they've already been enrolled and already been auto assigned to an AMH after auto assigned to the PHP. How long will it take for the change if they want to switch to a different Advanced Medical Home or primary care provider.

>> DOUG SEA: I can't remember the rule. I think in the case of emergency or more urgent medical condition, it's a matter of 24 to 48 hours. And maybe 7 days. Otherwise, I really don't know, that's just from memory. So somebody tell me if I'm wrong.

>> BRENDAN RILEY: Elizabeth, Meisha, do you remember or anything you want to add?

>> I don't remember the exact timing, but it is pretty quick, especially, if there's existing circumstances.

>> BRENDAN RILEY: Thank you, guys.

>> MEISHA EVANS: Yes, I agree.

>> BRENDAN RILEY: Great. Another question, we've gotten a few questions about medications and prescription drugs. I know we mentioned something briefly about this. But can someone answer this question? Maybe I'll put it to you, Elizabeth. On the medication side, will each plan have its own formulary or Universal formulary for all the plans?

>> ELIZABETH EDWARDS: So somebody may need to jump in if I say this incorrectly. But I believe it starts off with a Universal formulary. And then at some point, the state is planning to allow the plans to use their own formularies. But I could be mistaken by that.

>> DOUG SEA: That's exactly right. They can propose after year one, they can propose their own formulary. It has to be approved by the state.

>> ELIZABETH EDWARDS: Thank you, Doug.

>> BRENDAN RILEY: Thanks, Doug and Elizabeth. Someone asked if these question and answer will be saved for later review. This part of the webinar is being recorded and transcribed. So we will make sure that's variable for everyone so you can still review those. And we will dig through all the questions we've received. We'll see if we can make an effort to get back to you all on those.

I also got a comment from April over at the Community Health Center Association indicating that the enrollment broker is currently trying to schedule enrollment events but we don't know how many or where. So sounds like there's some activities in that front to do that outreach and education.

Another comment that we got, which is a little bit of a comment and a question that I thought would be helpful for to us clarify was regarding the ombudsman program and someone who had experience with the long-term care ombudsman. And I think some of this has to do with language. The long-term care ombudsman, we talked about that and you often need one San Fernando one individual. But with this ombudsman program with managed care, we're looking at a larger staff. Doug, do you know at this point? I haven't gotten through the entire RFP yet. But do you have an idea of the size?

>> DOUG SEA: They distinct specify that, but they did specify you have to accept a lot of phone calls, do a lot of warm hand-offs, and resolve a lot of problems any way you can. Track systematic trends in the problem and report that to the department. So I think that it's

going to be, it's going to take a significant, it has to be in North Carolina non-profit, by the way, who has experienced doing Medicaid advocacy. And I think it could take a team of groups to do all this work. Because it's a lot of people and there's going to be a lot of confusion.

>> And I can add something on that Brendan and Doug. In other states, the demand on the ombudsman program, they're called various different things in other states, whether it's a beneficiary support others has been high in the initial roll out period. Or when some of the grandfathering type of activities. So if a state can't change something for a certain period of time, then after that time period ends, there's been high demand on the ombudsman program. So it will -- it is a separate entity from our current care ombudsman, it's a separate entity, and it's doing something different. It's doing much more something beneficiaries understand the system and how to work within the system. And what kind of steps they need to take to make sure they're navigating that system correctly. So it is a different organization, a different entity. And it does other things and the demand will be pretty high initial.

>> BRENDAN RILEY: Thank you for following up on that. So another question is about provider network. So do we know at this point? And maybe I'll ask this of Doug. Do we know if provider networks are going to be available online so help from other brokers that can help beneficiaries figure out which one is the best plan to choose?

>> DOUG SEA: Yes, they're supposed to be. There's Maximus website. However, Maximus website doesn't even go live until late June, I think is what I heard. And the same time is when their toll-free number goes up. And then it's a matter of whether the provider directory has been submitted by Maximus by the plan and whether they're up-to-date. And, so, I think that even if you look one day and you see this is the provider network, I think at least during this initial roll out, there's going to be a lot of changes in that. And for that reason, you know, I don't know. It might be a strategy to wait until it's closer to the deadline to choose the plan if you're concerned and you think it might, the provider network might change during that time.

>> BRENDAN RILEY: Thank you, Doug. All right. We're getting a lot of really good questions in here. Let's see. We've got a few that came in earlier and I want to make sure I'm not missing anyone. So we've got a few questions about clinical coverage policy. I might send this one to Elizabeth and others can chime in if they have thoughts. So will there be one coverage policy? Or will each provider, I think they mean plan, have their own policies that are roughly identical. Basically, if there is a coverage issue, we need to identify the plan and have access to the materials. So could you talk a little bit about that, Elizabeth?

>> ELIZABETH EDWARDS: Sure. My understanding is that the state will issue the clinical coverage policy or keep the clinical coverage policy at least for the initial phases and plans to keep that some degree of monitoring.

>> MEISHA EVANS: That's my understanding as well, Elizabeth.

>> BRENDAN RILEY: Thank you Meisha and Elizabeth. Another service question I'll put out to you, Meisha. Someone said, when you say that CDSA are carved out, what does that mean? Also how or will this have -- what effect will this have on contract for providers and fee of services?

>> The CDSA, services provided by CDSA will remain in the fee-for-service model instead of moving to the capitated managed care. And I'm sorry, will you repeat the other part of the question?

>> BRENDAN RILEY: I think they were asking what kind of impact it will have for the providers for the CDSA?

>> MEISHA EVANS: I'm not sure I can speak to that, because it's not as though the services are being eliminated. It shouldn't have any effect on it. But I'm not a provider so, I can't really be sure. Doug, or Elizabeth, if you have any insight?

>> DOUG SEA: The part that's confusing here is even if you are enrolled in the standard plan, you will continue to get this service, anything that the CDSA is providing like speech therapy, occupational therapy, they will be, whatever it is, they will be providing that outside of the managed care system. And their provider network, whoever they've contracted with, that shouldn't change.

>> BRENDAN RILEY: Thanks, y'all. Few more questions. So here's a good general question. Just trying to put things into practice when the rubber hits the road. What will happen to a beneficiary who show up to a primary care provider that is not assigned to the PHP. Will they be denied service? Or will they be provided a service without a out-of-pocket cost?

>> DOUG SEA: The short answer is they will probably be turned away. And because the provider is not allowed to bill for providing, you know, now, obviously, if it's one of the services, for example,, one of the women's health service that you don't need it from PHP or fits an emergency of course, of course they will be treated and the plan has to pay.

But as long as the provider is in network, again, they still have to be in network. But otherwise, you will need, in most cases, a referral from that PCP before you go to somebody else.

>> BRENDAN RILEY: Thanks for that. Meisha, I'm going ask you this one. And maybe you and Elizabeth can tag team because it's enrollment related. For patients and LME and MCO, do they have to contract with the PHP or remain as fee-for-service?

>> ELIZABETH EDWARDS: In tailored plans, that will affect, the tailored plan is doing more physical health and behavioral health, in the next year, the person will continue to get their physical healthcare services through the fee-for-service system and they would not enroll into the commercial plan.

>> BRENDAN RILEY: Thanks, Elizabeth. All right. We still have a few more minutes if folks want to ask. We still have a bunch here if you have burning questions, feel free to send those in. Someone asked a question, which is what type of Medicaid I.D. or I.D. number will be used for the carve out services remain in fee-for-service?

Doug, do you want to take that one? Or maybe that's for you, Meisha.

>> MEISHA EVANS: Doug can absolutely take that question. [Laughter]

>> DOUG SEA: That brings up an important point. That people who are in managed care will no longer get the regular Medicaid card. They will rather get a card from their plan. That does, however, have their Medicaid I.D. number on it. But it will, you know, some people were afraid it will be confusing and wait a minute, I don't have Medicaid anymore. I've got this private health insurance. I don't even have Medicaid. So I can ignore that letter from Social Security about re-determining my eligibility. So we're concerned that this be clear to people. It's not like you're losing Medicaid. Your card is just coming from somebody different now. But because that I.D. number will be on that card, that is the same I.D. number that will be used for those carve out services.

>> BRENDAN RILEY: Thank you, Doug. We've got a few questions about supports for folks who may encounter various challenges. For lack of Internet access, lack of transportation, how will they access the enrollment broker given the challenges and given how much it may be phone-based if they're not in person and need assistance. Will they use the phone from DSS? Doug, I'll ask you that one.

>> DOUG SEA: That is a good question. And I don't think we have an answer to that. I think they are really relying on people to have phones and to have enough minutes on their phones. Or to have access to the Internet. And then they can click online and chat online with somebody at the enrollment broker.

But, we, you know, obviously, I know that people will contact their DSS's, because that's where they're used to going when they have questions about their Medicaid and then it's up to the DSS to help them get to the right place. And I know that the state is in the process of training all the DSS's on this transformation and warning them they may need additional staff to deal with the number of calls they're going to get.

But I think that there will be a lot of busy signals and a lot of DSS's after these letters go out.

>> BRENDAN RILEY: Thanks, Doug. One more question before we wrap-up. Unfortunately, we're not going to get to all the questioned today because we're running out of time. But we'll take one more question. And this is about residence in assisted living facilities. Do these impact people in the residence of assisted living care facilities?

>> MEISHA EVANS: Because of services covered not changing, just by the mechanism which they're funded, the move from fee-for-service to Medicaid managed care, it does impact them in that they will be either on a standard plan or a tailored plan eventually, but it doesn't mean they're care services will stop at the assisted living facility.

>> DOUG SEA: If I can just add, a lot of those folks in ACH's do have MediCare. At least for now, they're supposed to be out entirely, assuming that the DSS has, in fact they have medical care, but assuming it's in there, yes, they're out now if they have MediCare. However, if they don't have MediCare, then the issue will come up is there adult care at home and in that network provider? There are exceptions for people who are getting, for now, people who are getting long-term services for more than 90 days are carved out. But Elizabeth, help me. Is an adult care home within that exclusion?

>> ELIZABETH EDWARDS: I was actually trying to think that one through, because for many people in adult care home or similar facilities, the question also about which region their medical care home is in. But I don't think it's specifically carved out. I don't -- I'm trying to think through the LTSS part. We might have to get back to people on that question and think about it a little bit more and check the information.

>> BRENDAN RILEY: All right. Thank you, guys, so much. Thanks. We're going to wrap things up. I want to thank all of our presenters. Thank you Elizabeth, Meisha, and Doug and Lee for joining and Becka. Thanks, everyone who joined today's webinar. You asked a ton of really great questions. We're going to do what we can to get back to you soon as possible. We will be sharing a recording of this webinar as well as the slide, transcription, and the handouts that we provided today in a follow-up email. And, of course, when you log off, you will get a chance to fill out a quick evaluation survey. Please let us know what you thought about this webinar and if there's future topics you like to hear more about from us and dig into more issues of MediCare managed care. We know this is going to be a complicated transition and major transformation. And it's going to take all of us working together to try to make it the best we can as possible.

So, thank you, all for joining today. And we look forward to talking to you soon. Thanks so much! Have a great day!

[End of webinar]