

Post-Production FILE

**NC MEDICAID MANAGED CARE ENROLLMENT
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>> EDWARDS: Good afternoon, everybody, and thank you for joining us today. My name is Elizabeth Edwards and I'm a senior attorney at the National Health Law Program. Welcome to our second webinar regarding North Carolina Medicaid Managed Care implementation with today's focus on enrollment. Today we're joined by my colleagues Brendan Riley from the North Carolina Justice Center, Doug Sea from Charlotte Center for Legal Advocacy and Corye Dunn from Disability Rights North Carolina. Our webinar today will focus on enrollment issues regarding Medicaid Managed Care in North Carolina. What is supposed to be happening, what has happened so far and what to watch for moving forward. We will also leave plenty of time for Q&A. Before we get started, let's go through a few housekeeping items.

In this GoToWebinar interface you will need to join by telephone if you want to talk, although we will have everybody muted. You can maximize and minimize your Control Panel by pressing the chevron signal that's circled in blue. And as I said, all callers have been placed on mute but we really do want to hear your questions and feedback throughout the presentation. If you wish to ask a question, you can type the question at any time into the question box that's circled in blue. So go ahead and ask questions as we go through and we'll try to answer all of them at the end of the presentation. This webinar is being recorded and will be posted on the organization's Website.

It is being closed captioned so the recording will not be posted immediately. That will have -- the closed captioning will be done first.

The agenda. We're going to talk about, as I mentioned earlier, what's supposed to happen throughout this enrollment. What's happened so far. And what to watch for. We're also going to go over some resources for beneficiaries and some for providers and we'll do the Q&A.

So what's supposed to happen and who must enroll in Managed Care, who can, when and how. Now we're going to try to make sure that Brendan is connected. There he is. Brendan, are you there now?

>> RILEY: I am here. Thanks so much Elizabeth. We had a power outage there for a second. So bear with me if I fall out again. But I'm here now.

So thank you for that introduction and, like Elizabeth said, I am Brendan Riley with the Justice Center we're going to quickly cover some details about what's supposed to happen. So first, who is supposed to be in Managed Care and who is got other statuses like excluded or delayed?

So really we're talking about two major groups of populations, those who are in Managed Care to some extent and those who are out. The vast majority of Medicaid beneficiaries today fall under the mandatory enrollment category. Meaning they have to participate in Medicaid Managed Care and be enrolled in a health plan unless they fit into one of these excluded categories. So most folks are going to have to choose a plan or be auto assigned to one if they do not choose one. However there are also a number of folks who are in Managed Care as exempt meaning they can enroll but are not required to. They can remain in Medicaid fee-for-service, which will be called Medicaid Direct.

That includes the eastern band of Cherokee Indians as a Federally recognized tribe. And it also includes a number of beneficiaries who have serious intellectual disabilities, developmental disabilities or mental health needs until the tailored plans launch in 2021 which will be designed for those specialty behavioral health needs. Among the folks who are out and excluded from Managed Care, meaning that they cannot join a health plan no matter what and must remain in Medicaid fee-for-service, include those folks in on partial benefit Medicaid programs, like those who are on family planning, emergency Medicaid, as well as other special populations like those who are incarcerated in prison. It also includes a number of waiver programs. The CAP/C program. The CAP/DA program. Those in the Innovations Waiver and TBI waivers and a number of folks are also going to be delayed from Medicaid Managed Care enrollment. And that includes dual eligibles, children in foster care, and those who are residents of nursing facilities.

To help people who are going to be moved into Medicaid Managed Care, the state has contracted with an Enrollment Broker. And they are going to be responsible for -- or they are responsible right now for helping people understand Medicaid Managed Care, including what their roles and obligations, whether they have to enroll in a standard plan.

They also help people with the enrollment process itself when it comes to enrolling into a Managed Care plan. Of course the Department of -- the social services at the county level are still responsible for eligibility. But the Enrollment Broker will help people with the Managed Care plan enrollment. And they have to communicate with folks via the phone, online, et cetera to help people with that. And they are also responsible for

doing outreach and proactive community engagement to get the word out.

One of the things the Enrollment Broker does is provide choice counseling, which is accurate information that helps beneficiaries understand their plan options and compare them to best choose a plan that suits their needs. Mostly they will be helping people understand which plans their healthcare providers participate in. Because that's going to be the biggest most immediate difference to most beneficiaries when it comes to which plan best meets their needs. And they are also going to be, their enrollment brokers, for helping people disenroll or change plans, if needed.

So what we want to do now is we want to hear from you really briefly about your experiences with the Enrollment Broker so we're going to launch a poll. If you've had any contact with the Enrollment Broker we want to know, did they address your concerns?

So your options are yes, they helped address your concern or resolve the issue. No, they did not. Or that you haven't contacted the Enrollment Broker. So please go ahead and answer from these multiple choices and let us know what your experience has been like. We'll give you just a few seconds to answer this poll.

Okay. So we just closed that poll. I think we'll review the results of that later on when we get into the -- okay, here we go. We actually have it in front. So most of you have not contacted the Enrollment Broker. That makes sense if you're not actually directly right there with a beneficiary or have a family member as a beneficiary yourself. It looks like it's split as to among those of you who have had contact with the Enrollment Broker, those of you who did not actually -- most of you who did have contact did not find that they addressed your concern or resolved the issue and some of you did. So we would like to hear about those.

Please write us a note about those. And some detailed information about what kind of things you have contacted the Enrollment Broker with and why they weren't helpful. Feel free to send that into the chat or into the questions. We want to hear more from you. And we'll discuss that later on during the Q&A session.

All right. Next slide.

So as we mentioned, the Enrollment Broker will be there to help people choose their Medicaid health plan. For current Medicaid beneficiaries, they are going to have -- they have a 60-day open enrollment window to select their health plan. They will also at the same time be able to select their Primary Care Provider. Of course if they do not select a plan during that open enrollment window, they will be auto assigned by the Enrollment Broker to a plan based on some preestablished algorithm that the Department of Health and Human Services has helped create. However, that's not going to be Medicaid beneficiaries last chance to choose a plan when you're enrolled in one, you're not stuck in it. Once coverage becomes effective, every Medicaid beneficiary will have 90 days to choose a new plan. So to change their health plan for any reason whatsoever they don't need an excuse or any valid or invalid cause to be able to do that. And also that applies

to the mandatory population, those who qualify as exempt, those people who don't have to be in a plan, are able to disenroll at any time.

Members can also change their plans for good cause after 90 days so once that 90-day choice period is up, there are restrictions on whether people can change their plans or not, if they experience certain events that count as cause, they are able to contact the Enrollment Broker and change their plan. But there are limits on that. And of course every member is going to be able to choose a Primary Care Provider or advanced medical home within their health plan. I believe that they have two -- they can change their PCP I believe two times without cause during the year.

And here is a quick review of what the rollout schedule is going to be like for Medicaid Managed Care. As you all may remember, we are doing a phased rollout. So we're sort of testing things out in Phase 1 that's Regions 2 and 4 on your screen here in the light blue. Those are the counties of the Northwestern part of the state and the triangle and central northern part of the state.

Open enrollment there is already underway. It runs for another month. Until September 13th. And coverage in Medicaid health plans becomes effective November 1st.

Phase 2 will be the second phase. And that's when the rest of the state will roll out, starting in October for open enrollment. With coverage effective in February.

And so here is a more detailed timeline of what that looks like and the reminders that Medicaid beneficiaries are going to get about their opportunities to choose a plan.

So this is for Phase 1. Some of this has already happened. Before the open enrollment period went live the Department of Health and Human Services started mailing out information enrollment packets out to Medicaid beneficiaries who are mandatory or exempt.

The enrollment period then takes place for 60 days. That's underway right now for another month. Of course before that open enrollment period wraps up, beneficiaries do hear from the state again with a reminder postcard to make sure that they take advantage of their opportunity to select a plan. However, if they do not during the open enrollment period, you'll see that September 16th is when the Enrollment Broker will start doing the auto assignment. And assigning people to plans based on that algorithm.

Health plan coverage will then start November 1st in either a plan that someone was selected or assigned to. And that triggers that first 90-day choice period where people can change their plan without cause, no matter what. After that 90-day period that's when that lock-in period starts. So that's what that looks like for that Phase 1 timeline.

Now let's take a look at Phase 2. It's the same series of events with slightly different dates. But of course what might strike you is how soon Phase 2 does begin. Mailings would start going out to beneficiaries in the rest of the state next month with open enrollment starting as soon as October. Of course the same deadlines and benchmarks

and milestones that would take place, including coverage starting in February, the 90-day choice period after that and of course the lock-in period that follows.

That's what the timeline looks like. That was a quick review of what's supposed to happen which we think is an important primer about what has actually happened so far. So I'm going to turn it over to Doug Sea, the from the Charlotte Center for Legal Advocacy to cover that.

>> SEA: Thanks, Brendan. Yes, we're now going to sort of try to touch on what's been happening so far, what we have seen, what others have reported and some new developments that have happened as the process has gone on.

Now, as Brendan mentioned, the packets and letters were mailed out. And they were mailed out in early July. That was for Regions 2 and 4. The Enrollment Broker Website actually did go live on June 28th. Their toll free number went live on the same day.

And the plan Websites have gradually come online during this -- well, the last month. Although I will say that they still have a long way to go in terms of the content on those plan Websites. There's a lot coming soon you'll see at those Websites. Which is a bit of a problem for people who are trying to enroll who are looking for more information. And having trouble finding it. But today of course is the day that those reminder postcards are supposed to go out. And then there's less than a month, you know, now before the open enrollment period will end for these folks and then the auto assignment will begin.

Now, the Department has -- as anticipated, there have been some problems, some hiccups along the way. And to their credit, the Department has put out phone numbers that you're going to see when you get to Slide 32 later on to report those problems to them. And there's even a link there to how to contact their SWAT team that's trying to address these problems.

So here are the links to the enrollment letters. Originally in the last webinar we expected them to send out letters even to those who are excluded, like those on Medicare for example. But as a matter of fact they decided that would just confuse people and they did not send out letters to people who are excluded.

They also broadened a little bit who was excluded before they sent out the letters. Like people on the Innovations Waivers were not supposed to get letters from these.

But I will say that there are -- these letters do not say much about who is excluded. They just say, well, if you want more information about that, go to the Enrollment Broker Website. But unfortunately, when you go to the Enrollment Broker Website, it also has very little information about who is exempt and who is excluded. And the outreach materials that the Department created also really don't say hardly anything about that.

And so I think that this is part of -- we're going to talk in a minute about people getting a letter who perhaps shouldn't have or perhaps later they are going to become exempt or excluded. But getting information about whether you're able to get out of

Managed Care is hard to come by right now.

So moving on, the -- another thing I'll mention about those letters is there was no definition of this term Medicaid Direct that Brendan mentioned, which means fee-for-service Medicaid, you're not in Managed Care, except of course for behavioral health services through the LMEs.

But again, the letters and the outreach materials and the Websites don't really say what is Medicaid Direct. What are they talking about here? So I think there's some confusion out there about that.

Another thing, the packets that were sent out that had a plan comparison chart for people, along with the enrollment form when they were sent these letters, at that time there was no information about what the differences in terms of the extra what they call in lieu of benefits that the different plans would be offering. So that information was not -- is not in those packets.

Now, it is now up -- at this point it has been posted just recently at the Enrollment Broker Website. So you can find information there about the different optional benefits that these plans are providing.

Now, here is -- one way to enroll is through the Website. This is the Maximus Website, the Enrollment Broker's Website. And this is where you're supposed to go to enroll.

However, to enroll online, you have to create what's called an NCID account, which is a whole separate process before you ever get to this. So some people have had problems enrolling online. Luckily there are other ways to do it, which we'll see on the next slide, where you can -- basically you can enroll by telephone to the Enrollment Broker. You can download their mobile app. You can -- and here are the hours, by the way, that you can call in. They have extended hours during open enrollment. You can do it by mailing in that enrollment form that was sent out with the original packet. Or you can fax it in. And finally, they decided to locate Enrollment Broker staff at all of the county DSS offices in these two regions. And at -- they are also, of course, doing some enrollment at outreach sites where the Enrollment Broker is doing outreach.

So the first problem is that some people were erroneously sent mandatory letters saying they must enroll. And this was to some extent expected because the state had no historical data on those new to Medicaid or new to North Carolina. There were some other areas where they had limited data. And then the General Assembly did pass some language that was a little different than what the Department had wanted, which also caused some inconsistencies in terms of the law versus their methodology.

And the LMEs and some others identified errors such as people on the Innovations Waiver who got mandatory enrollment packets, there were a few people on Medicare apparently who got these, some in nursing homes who got these letters and who should not have gotten these. Now, to their credit, the Department has been working hard to correct those problems. Even calling people individually and saying, ignore that letter.

But you know, we don't know that they have been able to catch all of them.

But one of the main things they did is on the next slide, which is to put out some new guidance to specifically expand the categories of who is exempt and who is excluded and also to give people a way to raise your hand if we missed you and you think that you're exempt from having to enroll or should be excluded.

So the details in these are very complicated. And they are in the links below. There's actually a memo about it. And then a whole attachment with a bunch of detailed information. But basically what they did was they expanded some of the exemptions based on mental health or DD diagnosis. They excluded those who need substance abuse inpatient outtreatment -- intensive outpatient treatment or community residential treatment. And then they did release these Raise Your Hand forms. And they did make a lot of changes to those Raise Your Hand forms that we and some other people had asked for to their credit.

And another very important thing they did, that they determined if somebody is enrolled in a standard plan and they are identified as exempt or excluded, they will be automatically disenrolled, that is moved back to fee-for-service, effective with the first of the month after they are identified.

This is a very welcome change I think. Because this will assure that people can get like those services from the LME that they wouldn't be able to get from a standard plan for mental health or substance abuse or developmental disabilities. And if they want to go back into a standard plan and give up those services, they are going to have to specifically request to go back.

So this I think is in response partly to concerns about those folks and partly based on some language that the General Assembly put in. But I think it's very welcome.

The other good news is that they have an expedited process, like if somebody suddenly needs services they can only get from the LME, they can expedite the transfer. And the provider can send that in and can even get the effective date backdated to the date that they make the request so that they can go ahead and start providing that service without waiting for the agency to identify them and transfer them.

But this is sort of where the Raise Your Hand form comes in. And that's on the next slide. The Raise Your Hand form has been released now. And here are some links to it. There's one for beneficiaries to fill out, which is much simpler than the original draft. And then DHHS will then work with this contractor they hired to get additional information to determine whether those folks are, indeed, exempt based on the services that they need or the services that they have been receiving.

And they are going to request that information from providers. Now, remember, this is not just folks who were misidentified. It's also going to be folks whose circumstances change and who don't want to wait for the Department to identify them as being exempt and needing to get out of Managed Care and go back into the LME system. They can use this form to expedite that and get that moving quicker, we hope.

The decision -- by the way, now they are going to allow LME Care Coordinators or Care Managers even at the PHPs to help people fill out these forms. So that would be good because those are the people who are best equipped to help the persons figure out because they need to get back into the plan they need to be in.

And then if there is a decision to deny the request to disenroll and go back into fee-for-service, that will be appealable within 30 days.

So the -- here are some other problems that we have seen so far. The provider networks are still a long way from complete.

Most providers have been slow to enroll. Out of 89,000 only 3,000 had enrolled as of the day open enrollment started. And even after a provider enrolls, there's a delay before they actually get listed in the provider network at the Enrollment Broker or at the plan directory or at the plan Website.

So this is a concern. And DHHS has flatly said that beneficiaries may need to wait until information is more complete. They may want to wait before they enroll. Although, again, if they don't do it by September 13th, they will be auto enrolled. However, again, as Brendan said, the good news is that if the plan -- the provider network changes over time and they want to change plans at that point, they will have 90 days to do so after November 1. After the plan -- the effective date of coverage begins. And if all goes as scheduled, that will be November 1. Then they would have until the end of January to change plans without any reason at all and the Enrollment Broker is supposed to help them do that.

So here is a question, are you aware of providers in Regions 2 and 4 that have not yet enrolled with a Managed Care plan? Yes or no?

All right. So we're -- hopefully you've all answered it and we can close the poll here in a second. And then we should see some results.

And here they are. Most people are not sure. Some people are aware of this problem, though. So we know that it's out there, it's just a matter of getting it up to speed. A follow-up question, if you put in the comments, if you have -- if you know more is, in what specialties are you seeing this? Because we're particularly concerned about whether all of the specialties, especially like in rural counties, say psychiatrists or whatever, whether there will be enough network people who are accepting new Medicaid patients in those counties.

So what other problems are we seeing in trying to enroll? Well, as we mentioned, there was a lack of information about what the different benefits were until recently. And even now, if you go to the plan Websites, there just isn't a lot there. The provider networks, as we mentioned, are still not complete. The provider Website -- the Enrollment Broker's Website tools are hard to use some people have said. And the provider name is not showing in the right place. Or it's showing not in the right order.

Enrollment Brokers, when you call the Enrollment Broker, we have heard reports of them not having good information or current, complete information. And one example of

that I think, again, is who, for example. There's a Raise Your Hand process that there were some people who might have gotten the wrong letter, et cetera. But lots of other things they just haven't been trained on yet. And I think the Department is working to get them better training. Because they have heard some of these reports.

The plan Websites as I mentioned are definitely behind. I mentioned the next problem of having to create this NCID account. And then there were problems with being able to enroll your children and being able to enroll someone if you're the authorized rep. And the Department said they fixed those problems. If there are still problems there, that's one of the things we really want to hear from you.

So I think the Enrollment Broker, as I mentioned, we have said -- I think I've covered that. I think I'm ready to turn it over now. Yeah, I'm ready to turn it over even two minutes early to Corye Dunn, who is going to talk to us about what's coming next.

>> DUNN: Thanks, Doug. So we're going to talk now about what to watch for. And specifically what are the things that we are keeping an eye on and that really we could use your help to make sure we know what's going on in the community. Because the more people we have looking out for these problems, the more quickly we're going to be able to get responses from the state to correct them.

So I want to just give folks a sense of some of the possible sources of delay that remain. You'll remember that PHPs that unsuccessfully bid for a contract under transformation have appealed that decision. Their efforts to get the court to hold off the implementation of Medicaid Managed Care failed. But there's really no telling what happens as that litigation progresses.

There was a bill to delay rollout until next year that passed the House but not the Senate. I don't think it has any prospect of being renewed any time soon.

And DHHS has said that they can't go live November 1st in Regions 2 and 4 unless they actually get a budget by early September because they need money to actually implement the transformation process. So we'll be keeping an eye on the budget process and hopefully we'll get a budget in time that they can make decisions that make sense for enrollees. Although as of today there are really no signs that things have gotten any better on that front.

It's not quite clear yet what DHHS's contingency plan is. But we suspect that there is one. If in fact there is not a budget, it's not clear, for example, whether auto assignment will proceed and whether the enrollment for the other four regions that's set to start shortly after the budget would be needed would also be delayed.

Next slide.

So then let's talk about the ombudsman, this is a really important part of the program. DHHS promised there would be an ombudsman in place to assist beneficiaries and help resolve problems before enrollment begins and the Federal Medicaid regulations require a Medicaid ombudsman or similar beneficiary support for beneficiaries who need long-term services and supports. And at Disability Rights North

Carolina that's of course a lot of our clients.

When they released an RFP in March 2019 for the ombudsman role, there were no bidders. And bidders for a new RFP were due August 9th and there's supposed to be a contract awarded September 10th. We expect the ombudsman not to go live until January 2020. That means that if November 1 -- if the November 1 start date happens as planned, there will not be an external ombudsman available by that start date.

That also means that for now, the plan handbooks and enrollment letters and all of the information that's going out at this point won't have information about an ombudsman. And will have -- we have lots of questions remaining about the state will send a notice to all beneficiaries once that information is available. And will the plan and the Enrollment Broker have to update their materials once the ombudsman is in place.

Until then, that is until Januaryish when we expect an ombudsman to be in place, the Enrollment Broker is referring individuals to agencies for assistance. The Medicaid contact centers had additional training to try to help beneficiaries. And the Division of Health Benefits MC Medicaid has developed an internal response team to deal with concerns.

We also have some questions about the Raise Your Hand process. As Doug mentioned, the form for enrollees has gotten substantially simpler, which is great. But we're going to have to get into this process and try it out before we know how well it works or does not.

For example, will DHHS educate providers adequately on changes and on the Raise Your Hand forms?

How will the beneficiaries be notified of their right to self-identify as being in the wrong place?

Will new letters go to beneficiaries who got the wrong letter previously?

So these are not huge numbers. But for the folks who were affected, obviously it's a big deal.

And will the Enrollment Broker staff be trained on this process and be able to assist in completing the form?

And we're also not sure exactly how quickly a Raise Your Hand form will result in action. So if someone is facing denial for coverage of a needed service, then how do we make sure that those decisions are happening in a timely fashion and don't limit folks' access to necessary medical care.

Other questions that we have been thinking about, and maybe you have, too, is -- these are enrollment issues that we expect these scenarios to come up. And we're going to be digging in as we see them.

So is a particular beneficiary exempt from enrolling in Managed Care? Are they required to enroll anyway? And are they told of their right to disenroll?

If a beneficiary files a request to disenroll from Managed Care, will the decision promptly be issued on request in writing with appeal rights?

Are plan marketing practices and materials accurate with respect to these rights?

And is the plan provider directory accurate? We know that we don't have enough providers enrolling yet to have a good picture. But we also don't know if the ones who are listed are actually accepting new Medicaid patients. Just because a provider can bill that plan doesn't necessarily mean they are willing to take new patients.

We also want to make sure the Enrollment Broker is easily accessible and helpful to beneficiaries who need to choose a plan. And also can handle requesting an exemption or an effort to change a plan.

We would like to hear what you all think about the Enrollment Brokers providing current, accurate and unbiased information. And whether a beneficiary with good cause will be able to change plans sufficiently after 90 days and whether the plan and the Enrollment Broker will convey that information clearly.

And that again about the promptness, if a request to change plans is made, will that be acted on properly and promptly by both the Enrollment Broker and the plan?

For folks who are not currently tailored plan eligible, if their mental health condition worsens so that the need for enhanced mental health services arises, will the beneficiary be smoothly transitioned from standard plan to the LME, without interruption in care and delay in getting needed services? And if a beneficiary begins receiving Medicare or starts getting CAP/DA or CAP/C services, will she be promptly disenrolled from Managed Care?

Now, the rest of these slides are resources for beneficiaries and advocates. And I expect that you'll want to hang onto these and refer back to them.

For issue resolution we have the phone numbers for providers to contact NCTracks. For beneficiaries to contact the Medicaid Contact Center. And for counties to contact NC FAST. Remember there isn't yet an ombudsman yet in place. So the Medicaid Contact Center is the default ombudsman for now.

When needed issues can be escalated to the DHHS SWAT team. Phone number and email listed there. This is actually a really important development and we're grateful to the Department for creating this SWAT team. DHHS staff can also escalate issues to the SWAT team. So if you see something that you believe is a real -- not just a simple mistake but a structural problem we want folks to use that to get systemic resolution rather than just resolution for one enrollee.

This is the process for issue resolution that the Department has put out. We have all of the existing channels. We all know people will go to their providers, the county legislators, will use their existing channel for raising issues and asking questions. And the SWAT team will be doing the Command Center intake. They will keep an eye on emerging issues and make sure that appropriate calls are escalated from existing channels to a leadership level.

And the folks involved in that Management Team level are transformation program leadership, technology folks, county coordinators, and then members and providers.

And of course that all has to be coordinated with the checks, which I'm glad is not my job.

If beneficiaries have questions or problems, these are the resources available to them. Disability Rights North Carolina works statewide but only on behalf of people with disabilities. Legal Aid of North Carolina is almost statewide, except if you're in the areas served by Pisgah Legal Services or the Charlotte Center for Legal Advocacy.

And then these are just some really helpful links if you're looking for information put out by DHHS or the Federal Government. And then the -- actually these are all of the DHHS ones. Except for the Justice Center has just put out a Medicaid transformation subpage to collect a bunch of important stuff. So that's a good place to look if you can't find what you need on the DHHS Website.

All right. So what can you do? Spread the word. What we mean is spread good information, correct information. Not just what you fear might be going wrong. But in fact what you've seen.

And to help folks that you interact with get correct information about their eligibility and the eligibility of folks they support.

We also think it's really important that folks in this community who are already served by Medicaid be really clear about the need to support expanding Medicaid and closing the coverage gap. Of the 5- or 600,000 people who would be eligible for Medicaid under an expansion, we expect that many, many of them are people with disabilities who can't get health insurance through employment. And who don't qualify for a Social Security Administration determination of disability.

And so now I think we're going to open it up for questions. And --

>> EDWARDS: Yes, thank you, Corye. We have a fair number of questions already in the queue but please feel free to add more to the questions box. And we'll try to get to as many as we can. And if -- I think we're going to try to answer other questions we don't get to after the webinar.

So I think we have a quick one -- we have several about people in residential facilities. So for residential facilities, how will they determine or know what residents would be considered for a tailored plan? And would that include any resident with a mental health diagnoses? Corye, I think I'll throw that one to you.

>> DUNN: I'm sorry; I'm trying to read the text along with hearing what you said and I'm not seeing that one so I really want to --

>> EDWARDS: So I just tagged you in it. But for residential facilities. How will they determine or know who residence would be considered for a tailored plan? And would that include any resident with a mental health diagnoses?

>> DUNN: Got it. Thank you. So it is not any resident with a mental health diagnosis. It is a resident who uses or has used in the recent past enhanced behavioral health services that are only available in a tailored plan.

So if a person has a significant mental illness but does not actually access services,

then they may be put into a standard plan. If someone believes that they should be receiving enhanced services only available on a tailored plan, though, that's what the Raise Your Hand form is for and so I expect that residential service providers will be some of the folks who are assisting enrollees with filling out those Raise Your Hand forms.

>> SEA: This is Doug. If I can just jump in, there are actually two ways. The one is based on diagnosis alone and the other is based on your treatment history. And the guidance that the slide was saying earlier about the August 2 guidance, there's a great bit of detail in there about what it takes in both of those categories and the new changes that they have made and who their going to move automatically if they identify them properly based on those criteria back into fee-for-service in the LME process. But if you go to that link about the August 2 guidance and read the details of that, you will see exactly what the criteria are.

>> DUNN: This is also true for the follow-up question on folks with IDD. So more folks with IDD will -- people with IDD are more likely to be automatically assigned to the tailored plan, therefore, left right where they are with the LME and fee-for-service medical care. But again, if you think someone is wrongly assigned, that's what the Raise Your Hand form is for.

>> EDWARDS: Thank you, Corye. And Doug, we have a few questions about dual eligible that I'll give to you. When they phoned the Enrollment Broker to ask if a dual eligible needed to select a health plan, the Enrollment Broker was unable to tell them whether the dual eligible needed to enroll. And they could only tell them for a specific individual. And also to build on that one, as well, if someone is currently in a Medicaid only plan -- I'm sorry; answer the first one first about dual eligibles, if you would.

>> SEA: Yes. I mentioned earlier that the Enrollment Broker Website, that the packets that went out, that there's not much information out there about who is exempt. Now, there's a good -- if you go to the county DSS playbook, which is available at DHHS's Website, at the transformation Website, they have a really good summary of who is exempt and who is not. But I don't find that a lot of other places. And it's not in the outreach or the materials sent to beneficiaries.

So it's understandable beneficiaries would be confused. And their providers. It's not a good sign that Enrollment Broker staff do not know that people on Medicare not only don't have to enroll, they can't enroll. So that is I think another example of why more training is needed there.

>> EDWARDS: So a follow-up question on dual eligibles, Doug, what happens if a person is currently on Medicaid only and then is put into a PHP but then they age into Medicaid? Do they stay in the PHP or are they disenrolled back into fee-for-service?

>> SEA: They are supposed to go right back into fee-for-service. Now the Department has said in the past that they are going to run this report on a regular basis. Run a report that says, oh, okay, this person is now showing up as having Medicare.

Therefore, we're going to automatically switch them back to fee-for-service. And we have a letter we will send them saying, we are now sending you back to fee-for-service.

However, I don't think we know yet how often they are going to run that report. And furthermore, if a DSS worker fails to put into NC FAST that the person now has Medicare, they may not touch the case for a while, may not know it unless somebody calls them and they put it in, then it may not show up. So this is again where the Raise Your Hand process is going to be needed. That people are going to have to call up and say, I now have Medicare. I need to disenroll. And I may need to fill out this form even to do that.

>> EDWARDS: Thank you, Doug. We have two questions sort of on where information can be found. I wanted to highlight the previous slide. Somebody asked where the first webinar in this series can be found. It can be found on North Carolina Justice Center's Website. And then somebody else asked if the one pager that is uploaded in the handouts would be available in any other major languages spoken or read by North Carolina Medicaid beneficiaries? I believe -- Brendan correct me if I'm wrong, I believe that one is available in Spanish.

>> RILEY: That's correct.

>> EDWARDS: Is that available on the Website.

>> RILEY: That's right. It's up on the Website. And it's also available on this GoToWebinar as one of the handouts as one of the slides for today's webinar so you can go ahead and download those right now from the GoToWebinar pane.

>> EDWARDS: Thank you, Brendan. So we have a few -- we have quite a few questions left. I'm trying to find them.

Brendan, I'll ask you this one, if there's a delay in the November 1 implementation due to budget approvals, with the beneficiaries continue in a fee-for-service service until an approved date? I think we covered that. But can you answer that one?

>> RILEY: Yes, this is a great question. And to be honest, there are a lot of questions about what happens if there is a delay. And I think as you get down into the details, I think a lot of those things are not yet set out so I think we'll learn as time passes if it becomes more real that we might be facing a delay.

But ultimately, yeah, I believe that if Managed Care rollout is delayed, that current Medicaid beneficiaries who would have otherwise been enrolled in a standard health plan will remain in fee-for-service. So that would be I assume what the implications of a delay would be.

>> EDWARDS: Thank you. And also, Brendan, in regards to the lock-in period, will beneficiaries have an opportunity to change plans any time during the given year? Like a special enrollment period.

>> RILEY: That's a great question. And yes, there are -- similar to a special enrollment period for folks, after their 90-day choice period has ended, there are certain events or qualifying activities that will be with cause or for cause reasons they can

disenroll and choose a new plan. Some of those include moving to a different region. Some of them include whether a service they need is not provided adequately by the plan. And there are a few others that we can link to that should be available that are required in the contracts. I'm not sure if they are yet available in a stakeholder-friendly material that the state has put out. But there will be some limited opportunities for folks to change plans, if they have a qualifying event.

>> EDWARDS: And Brendan, we also have several questions about where can people find plan comparisons. Can you discuss that briefly?

>> RILEY: Absolutely. So there is a plan comparison chart that the state has made available to compare the four statewide plans as well as the fifth plan that's available in two regions. You can find those either through the Medicaid transformation page that DHHS maintains. I think an easier way to find them might be through the NCMedicaidplans.gov Website that the Enrollment Broker maintains. You should be able to find a chart that compares the plans.

Largely it is a short chart because as we know most benefits are the same and there's no change in costs from plan to plan. That chart does list differences in value-added and optional services that those plans can provide.

I think what would be most important for many beneficiaries is the difference in provider networks so whether their preferred providers are participating or whether a provider that are nearby to them geographically is participating in that network. And that is something that you won't be able to see through a chart. That's something you'll have to probably contact the Enrollment Broker either by phone or through the Website and chat to get those kinds of answers.

>> EDWARDS: Thank you, Brendan.

Doug, I'm going to ask this question to you. When I phoned the Enrollment Broker to ask if there was an in-person assistant available, I was told no. There was only an in-person only if there was an in-person event. Can you provide some tips on that?

>> SEA: Well, it was a fairly recent development to add Enrollment Broker assistants at DSSs as well as at outreach events. And I think that they may have been assuming that there was enough for those people to do. Because so many people don't understand the letter and contact their DSS anyway or go to DSS with the letter. And I think that's what the Enrollment Broker staff at DSSs are trying to deal with. And it's only one person per DSS I think. So that may have been why they said that.

>> EDWARDS: Thank you, Doug. And we had another question about beneficiaries finding out who their Enrollment Broker is and how to contact them. So I can answer that one.

It's a general Enrollment Broker. Each beneficiary does not have an assigned individual as an Enrollment Broker. So they should just be contacting the general number for an Enrollment Broker or going to their DSS office or contacting them there.

So the main source is going through the main Enrollment Broker number.

We just answered that one.

So we have one question, Corye, based on the -- a person on an Innovations Waiver received eight pages saying that they would stay in North Carolina Medicaid Direct causing confusion. Should she have even received that information?

>> DUNN: Whether she should or not, she did. So there have been changes in plans over time about what enrollees who will be tailored plan eligible will receive. Medicaid -- because Medicaid Direct is what they are calling fee-for-service, I expect there will be a significant amount of confusion about this. And we would love to see that letter, if you would like for your -- for the enrollee you're working with to contact us.

>> EDWARDS: Thank you, Corye. Brendan, I'll throw there one to you, can you go over again what does delay mean on the in/out charts? When will these groups eventually be enrolled in a Managed Care plan?

>> RILEY: That's a great question. So when we're talking about delayed populations, we're really saying that they are excluded. That they cannot participate in Medicaid Managed Care at this time. They remain in fee-for-service.

Those folks are delayed for a number of reasons. I believe that the time is until 2024 when the next five-year period of the waiver approval is up. I can't remember if that's the same thing for the foster youth population. Because I know they are exploring another plan option for foster youth.

So the short answer is for several years. So right now those folks don't have anything to worry about until there's some new policy decisions made about incorporating them. But I can't provide additional details. I don't know if other speakers on the webinar have answers on that or want to weigh in.

>> EDWARDS: Sounds like not.

Doug, I'm going to ask you this question, is there a way to see if a beneficiary's application has already been approved? And also is there a way for providers to see if a beneficiary has chosen them as their PCP?

>> SEA: By application I assume you mean their request to be enrolled with a particular plan. And in terms of approval, it's really -- it's not -- it doesn't need to be approved. If you enroll with a plan, you are enrolled with that plan. Now, if you're talking about a request to raise your hand and disenroll, there will be a decision that is issued by the state or by its contractor. And that will say we have approved or disapproved your request to disenroll. And you can appeal, if you don't agree with that.

That's also true I think if you request to change plans if it's for good cause. If it's not sort of an automatic thing. Then they would have to issue a decision and give you appeal rights if they don't allow you to change plans.

>> EDWARDS: Doug, can you provide more information on where people can find out what does good cause mean?

>> SEA: Good cause to disenroll or to change plans? I think if you go to the transformation -- the Medicaid Reforms Website and you go under their policy papers,

which is a square at the bottom of the page. You link on that policy. And you click on policy papers that have been issued.

There's a great deal of detail in those policy papers about -- and there's also a couple of links to webinars on the public information part of that webpage that one of them is specifically for beneficiaries and how the beneficiary process will work. So there's a lot of detail there.

You just have to look for it. It's kind of hard sometimes to get through it all. But it is all there.

I think that when we -- there's also a good bit of information in our first webinar. If you look at our PowerPoint from our first webinar, there's a fair amount of detail there, as well. But we are going to be I hope doing more webinars in the future. And certainly we can try to cover that in more detail then.

>> EDWARDS: And if people have any special requests for types of webinars, please, you can put that in the chat box, as well.

We have had several questions about children with special needs, ages birth to three who have Medicaid and need specialized therapy such as PT, OT and speech, and whether or not they are affected by this plan. Corye, can you take that question?

>> DUNN: Sure, so children age zero to three will generally be enrolled in the standard plan. And so many of them will be enrolled starting in that -- in this first phase.

What is important to remember is that every child who is enrolled in Medicaid is entitled to EPSDT, early periodic screening diagnosis and treatment. And so whatever is medically necessary for that child should be provided.

Now, if you are already receiving services through a CDSA, we would really love to hear about your experience with the coordination of those services with the services provided by the standard plan. This is one of the challenges of the transition that we don't have a lot of clarity on I think. And so for young children who are receiving services through a CDSA and are then assigned to a standard plan, we would love to hear whether that's a rousing success or a total disorganized mess. We would really like to hear what your experience is.

>> EDWARDS: So Corye, we had a follow-up question from the person who had the letter about the Innovations Waiver. And I think there might be a follow-up on this one. How do you want people to contact you with that information?

>> DUNN: Sure, the easiest way is to go to our Website at disabilityrightsNC.org. We have an online intake form. And you can share the information there.

You can also call us at 919-856-2195. And that information is on the slides. So you're not going to lose it.

>> EDWARDS: All right. So just to wrap up today's webinar, thank you, everybody, for coming. We will post the webinar -- the slides for the webinar and the recorded version of the webinar on the Website specifically on NC Justice's Website a few days after today for the webinar to be closed captioned. The slides are available in the

handout box of the webinar currently if you want to go ahead and download those.

And as we said, we will be doing future webinars, as well, so if there's specific topics you all think that really need to be covered, please let us know and we'll try to cover those. But otherwise, thank you for attending today. We will try to follow up with questions. And please have a good day. Thank you, everybody.