NC Medicaid Managed Care Transition Update Webcast
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>> Good afternoon, everyone. The webcast will begin in a few minutes. Please make sure you are using a computer with audio and that the audio function is on and the volume turned up. Due to live streaming, you may experience a slight delay between 30 to 60 seconds. There is no dial-in number for this webcast. If you have any technical issues now or during the presentation, send a message using the ask a question box located on the left-hand side of your screen.

>> Good afternoon and welcome to today's webcast. I am Tracy Zimmerman, Director of External Affairs for the Department of Health and human services and I will be your moderator today. Before we get started, here are a few reminders about webcast technology. Please make sure you are using a computer with audio or a smart phone connected to the Internet and that the audio function is on and the volume turned up. If you experience any technical issues during the presentation, send a message using the ask a question box on your screen. Resources for this presentation are located on the left-hand side of your screen. Questions can be asked at any time during the presentation. We will answer as many questions as time allows for. This event is provided by relay captioning services and a link is provided at the bottom of your screen. I would like to introduce your presenter, Secretary Mandy Cohen.

>> Thank you. Great to be on with all of you. More than 1000 folks have registered, and I thank you for taking time to learn more about the transformation to Managed Care. We will go through a slide presentation and then we will get to your questions.

As a reminder, open enrollment is now live for the entire state of North Carolina, which is very exciting. We originally intended to go live with Managed Care in two phases. We started open enrollment back in July for that light blue area that you see in the northern part of the state and then the intention was to go live in a second phase with the darker blue area. Because of some of the budget uncertainty that was happening in Raleigh, we needed to combine those phases and now we are having open enrollment for the entire state, starting now until mid-December with a go live for all of the state to turn on Managed Care by February 1, 2020. No matter where you are in North Carolina, you should be experiencing open enrollment now.

Our friends in the light blue area have been in open enrollment back since July and have experience with this. We know that for the majority of the state, this will be new for some folks and we are excited. If you are new, we are glad you are joining to learn more about it. Let me step back before we move forward and remind us how we got here.

On slide three, you will see, remind folks that back in 2015, the North Carolina General Assembly enacted a law which directed our department to transition our program from its current state administered fee-for-service program to Managed Care. We will talk about exactly what that means. Essentially, moving from a state administered program to a private insurance company managed program.

Just to talk high level about our vision for transformation. We want you to understand where we are headed with things. We wanted to make sure that this transition was not just about the functional transition of moving from a state administered program to Managed Care, what about improving the health of North Carolinians through an innovative whole person centered and well-coordinated system of care that addresses the medical and nonmedical drivers of health. We are hoping this opportunity is of major change for our state. It also can propel us forward in terms of holding a healthier state.

To briefly go through some of the features of Managed Care, Medicaid services are going to be paid differently under Managed Care. Again, currently, one of our Medicaid beneficiaries is seen in a doctor's office or hospital, currently, the state pays that doctor or hospital directly. And Managed Care, the services are going to be paid differently. The department is going to contract with private insurance companies that will call health plans or prepaid health plans as we move forward. We will pay a predetermined set rate per person, often called a capitated rate for each person that is enrolled in a particular plan. We have a number of policies that sets the rules of the road because while it will be a private insurance administered program, the state still sets up the rules of the road that includes things like minimum rate boards for certain providers, we pay a certain amount per primary care providers right now. We have a minimum rate floor to make sure that our providers continue to get paid and our beneficiaries have access to folks going forward, the health plans are now going to be the ones accountable for managing care and making sure that folks are getting the right care at the right time.

Beneficiaries for the first time in North Carolina Medicaid are going to not just be found eligible for Medicaid, but now they are going to choose a health plan, as many folks who get their private insurance through their job and may have a choice of health plan, now our beneficiaries and Medicaid will have a choice of a health plan, and we have an independent enrollment broker facilitated through a call center and another mechanism that is going to help beneficiaries choose the health plan that is right for them.

Slide 6, lists just a few different ways for folks to get in touch with the enrollment broker and to do the selection that is needed. So, the call center is the major way in which folks can get that counseling from these independent folks. That call center number is here, 833-870-5500. We also now have a website where folks can go and look at their options for enrollments on NCmedicaidplans.gov and we also have a mobile app you can download and look at plans. To remind folks who are the choices, we had a very competitive process in which we chose partners for this program.

Our prepaid health plan partners, you will see them here on Slide 7 along with their contact information, their website and their phone numbers. The plans are Well Care, United Health Care, Healthy Blue, Ameri Health Caritas and Carolina Complete Health. The first four are all available statewide. Carolina Complete Health is only available in regions three, four and five. Before I turn it over for more specific details to our Managed Care, I want to remind folks here about what we are focused on the department in terms of our day one priorities. This is a big change and we know that changes like this are hard and bumpy, no matter how well you manage all the details. I will tell you, we have folks working seven days a week here on getting ready for this care transition and we have been doing that for many months. But we are focused on some very key priorities for the day one of Managed Care and that day is February 1, 2020.

We wanted to do what seems like basic things that are actually very hard. We want to make sure that a person with a scheduled appointment is seen by their provider, that folks are going to have new insurance cards, that they are going to be bringing to their doctors' appointments. We want to make sure if someone's schedule says see that what Doctor, they get seen. We want to make sure to get someone's prescription filled when they need it, so they can have access to their medicine, and we wanted to retain our wonderful providers in our Medicaid program. We are a state that has an incredible number of providers in our Medicaid program and we want to make sure that our providers stick with us and with this program in order to be access points for our beneficiaries. We want to make sure they are compensated for the care they do deliver for our members. Those details involve a ton of work as I said, on the states part, the PHP's part, our county partners and many others to get ready for this transition. That is why I thank you again for joining us for this webinar today and to dive into a few more details, I will turn it over to Dave Richard, our Executive Director for North Carolina.

>> Thank you. We are going to look at the next slide now. You will see on this page, we have timelines for Medicaid transformation. I will go through some talking points around these to make sure we all understand. It is important to know that we have obviously mailed packets to everyone across the state that we are going to Managed Care. We began open enrollment back in July for regions 2 and 4. We extend that for those regions and we are in Open Enrollment for the rest of the state. We have a bright yellow line around the item, provider contracts must be signed for inclusion in auto assignment. We are going to make sure, as we think about this, these are primarily providers that are primary care providers because we want to make sure we keep those relationships in place. We want all providers to work towards finding contracts as soon as possible. Open Enrollment will finish on December 13 and then we will start off auto assignments on December 16. We are scheduled to go live with the entire state on February 1, 2020. Let me mention a couple of things about why these dates are important and what makes it important.

Beneficiaries do have the option to choose Medicaid health plans during the Open Enrollment period. That is important, we want people to know that. That is why you hear a lot from the broker about how best to do that choice and we really want folks to do that. We want to continue and make sure that people are doing that up until the December date, today we have over 69,000 individuals who have signed up for health plans, a significant number of people, that is significantly lower than the 1.6 million people that will go into Managed Care. We want to move that number. It will end on December 13, on Open Enrollment period. At the end of that, we, at the state will do an auto assignment process to make sure that every beneficiary going into Managed Care will have a health plan assigned to them.

It is important to know about that auto assignment process and how that works for our beneficiaries. For our population that has gone into Managed Care, here is the way that it will work. First is that their geographic location, we would not want to assign somebody to a plan that is not in the region in which they live. That is the first and foremost. Secondly, a special population. For some individuals, those peace and will be going into a Behavioral Health Tailored Plan, they will not be assigned a health plan, or a member of a federally recognized tribe. They will not be assigned to a plan. With them, we go, this is the most important reason to look at this November 15 date for primary care providers to make sure they are contracted is that we want to keep the historic relationships with the primary care physician or provider as we make assignments to health plans. So, if an individual has position X and they are only enrolled in two health plans, we want to make sure they are assigned to that health plan or the health plan can make sure they are with their primary care physician.

Then we wait to make sure we look at, for people that have, excuse me, for other family members who want to look at those family members to make sure that we are assigning their health plan to be inside it, then we will go to where people have been, once we have gone live with Managed Care, and a health plan where they go off of Medicaid and go back to Medicaid, we will assign them to the plan they had previously. Finally, we have to do an equitable plan distribution to our health plan. We will consider all these things, but the algorithm will make sure those health plans have the base number of individuals in their plan to be successful as we go forward. Really important to note that for individual primary care providers, if you signed up by the November 15 time, that is important for people to be able to get that.

Next slide now. I think we have said it multiple times, the transition into Managed Care is the biggest thing we are doing in North Carolina Medicaid. This is a large rollout. With any rollout of this side, there are going to be questions that will arise and issues that will arise. As the Secretary mentioned, we are committed to making sure that beneficiaries get their services, providers get paid and we are committed to doing everything possible to resolve those problems quickly.

So, we go to the next slide. I want to make sure you know how to get in touch with us because what we do not want to do is have people searching, so this slide indicates where you can reach us, the providers, the beneficiaries, the Medicaid Contact Center, counties and staff. Staff can escalate issues. A SWAT team is focused on identification. When needed, issues can be escalated to the SWAT team directly by calling the number here. We know that there are issues that have been identified and we are working on those issues to provide a directory, looking at the search result question, I think you are seeing functionality improve, but we continue to work on those. Now, make sure that if people are going onto the website, we will talk about this and they are not finding their physician, they can call or talk to a counselor

who understands the best way to move forward. Most important thing, we do not want people who are having questions not to ask those, so please make sure you pay attention to the managing chain, so you can get in touch with the right people.

Next slide is just an indication of how we support beneficiaries. I will not go into that because the enrollment broker, Eric, will talk a lot about this so people have that.

We will go to the next slide. This shows how we are supporting providers. Beneficiaries will go to their provider with information. So, we are providing a playbook that is available. You will see some of those items on this slide.

Next slide, AHEC is supporting training to help them understand this transition as we are going forward. We have connections to the PHP's that are working with their providers and connections to DHHS. We are doing virtual office hours, engaging with providers and associations on a regular basis.

If you see, the next slide, we have the indications of the things that we are doing that show the kind of information that we are providing to providers. Here is the information, make sure you contact us. There are several issues and items that we provide to providers to help them. Counties are going through a significant change, we have done a great work with these doing onboarding sessions with them, working on cross functional training with health plans, monthly webinars, virtual office hours, our enrollment broker is on site for in person support with the counties. Our staff are on-site for inpatient support. We have the county playbook, which is great for our counties and we are doing weekly updates for our county DSS workers. In the past year, we have reached out to more than 70,000 people face-to-face, meetings and webinars including counties, providers and individuals. It may not be enough, but we continue to do that outreach. We will continue this work.

This next slide shows the County Playbook that we were describing. It helps our counties understand the specifics about what we are doing. You see the County Playbook up there, this is the kind of work we have been doing and we appreciate the collaboration we have had with County partners to get this. It has been a good collaboration between the state and counties to make sure we are getting this rollout. We know that there might be some legislators on our call, and we want to remind legislators that we have the SWAT team available for them as we move forward with this. We will have additional conference calls with legislators specifically doing Open Enrollment, we tend to have information sessions with legislative aides to make sure they understand as we get ready to go live, and we will have additional resources and playbooks available for legislators. We want to tell legislators that we know constituents will call in and what we don't want legislators to do is have to worry about having all of the answers at their fingertips. We have the resources that we can respond in the typical ways in which they reach out to our team is also available for them to do that. We want to remind folks that we are doing everything we can to educate our counties, providers, legislators about how this transformation will work. We know there will be issues as we go forward. We address them rapidly. We are committed to this and committed to the work we are doing on behalf of our beneficiaries. We will now turn it over to Eric with our enrollment broker to walk through the next series of slides that describe the work they are doing.

>> As Secretary Cohen described, the enrollment broker is responsible for choice counseling for Health Plan and PCO selection. We are privileged to be doing this work with North Carolina. We do it throughout the country and we really are an impartial third party. We have no financial relationships with any organization in the U.S. and our focus is to ensure that each and every beneficiary gets enrolled in the right plan for themselves and for their families.

As it has been highlighted, there are a number of ways people can reach out to the enrollment broker. One of them is the website. There is a tremendous wealth of information on the website. Not only can you go out to enroll, but you can go out there and find out about outreach activities are in your area. You can go out and find about any questions dealing with transformation. You can find a number of tools to help you make your decision. We do know that a lot of people would like to talk to a human being, so we certainly have specialist ready and able to take calls right now, we are open seven days a week, 7 AM to 8 PM, so people are ready to take your calls. We have armed our enrollment specialist with additional information about providers and their affiliations, so we can ensure we get people the most up-to-date

information, so they get the provider of their choice. We do have a mobile app. You can actually go out and not only find a provider, you can enroll via the mobile app, just like you can online, and we have thousands of people who have done just that. For those people who have hearing impairments, we do have a TTY line set up. All the websites have been looked at and certified, so they can be used with screen readers. There's a population that utilizes those devices. The other thing people can do is they can mail or fax their enrollments in. Today, we have received thousands of enrollments, so we do know that that is one avenue that people are using heavily.

We are going to go through a number of notices. I realize that many of you are looking to some small PCs. Everybody look at the bottom of the slide, this is where you would download each and every one of these forms. You will be able to get the most up-to-date notices that are available. One of the things we have tried to do with the notices, you will see here in the highlighted red box, we tried to make it clear who the notice is coming to. You will see right up front, it tells who this is for and many will see in the middle part of the screen, there are three steps to enroll. We really try to make it very easy for people to understand what they need to do, and we tried to break it down into these three steps.

So if we look at the sample mandatory notice on the next slide, I think you will see a lot of similarities again, right up front in the red box who this notice is being sent to and then again, if you have got questions, what you need to do, I want to point out at the bottom of every letter, every notice, every postcard, you will find the toll free 833-870-5500 number. That is the number to call and get help. You will also find the same information for the TTY lines. It is on all the notices as well. You will find references by going out to the website.

As we look at the next slide with the sample excluded notice. You see the same type of theme with the beneficiary. This is clearly right up front. There should be no confusion. Again, if there are people who will find this information very quickly and the number that they can call.

Sample exempt notice also follows the same pattern. One of the things we have tried to do here as well is just make sure that people are clear on what they need to do. You will also notice people can choose a new plan at any time. If there is something different or unique to a population, we do try to call it out. I think you will notice we have kept these notices as short as possible and they have also been through a loop within our organization, the Center for Health Literacy that specializes on communication for the Medicaid population.

On the enrollment packet, every enrollment packet gets an informational flyer. You will see step one, step two, step three repeated here, so the same message is communicated to beneficiaries and they are getting it over and over again, we are trying to reinforce them with all of their communication, clearly you can see the callouts for the 833-870-5500 number for the contact center, as well as some information about additional languages.

Every enrollment packet gets an enrollment form. As I said, we received and processed thousands of thousands of people mailing forms. Again, very simple, very straightforward. Each one of these comes out in an enrollment packet is individualized. There is barcoding so that we can quickly and accurately process with ease and we know that these are being very heavily used.

One of the items being updated is recent changes to the comparison charts. These are not only available via the enrollment packet, they are also on the mobile app. You can go out and see which plans are available in your county, especially when you search online. Then we can do an actual comparison via the website or the mobile app. These particular enrollment packet comparison charts have been updated with the latest information about Carolina Complete Health and these will be mailed out in the coming weeks as new people get enrollment packets. There is a number of different things we are doing.

There are also postcards we are sending out. I think it will be on the next slide. There has been changes, there is going to be a special postcard sent out in the coming weeks. This is really to alert people they have got some additional choices to make and we think, we know based on mailing these out recently that these are very well received. We will take action based on these postcards.

The enrollment packet contains other additional information and it talks about not only nondiscrimination, but more importantly, there is help in a variety of languages. There are 15 languages listed in addition to English. We can support many many more through the language line. We want to make sure that again, we are meeting people's needs and if they speak a language other than English or Spanish, we can assist them.

We just talked about one reminder postcard coming out in Region 4 and you are now seeing there are others coming out. As we get close to the end of Open Enrollment, people who have not yet made a choice will be receiving this reminder postcard. It will be mailed starting in early November, but we will make sure these are out to all of the eligible beneficiaries by November 15, so they have plenty of time to make their choice prior to the end of Open Enrollment.

Dave alluded to the fact that one of the primary other responsibilities besides managing the call center and sending out notices is outreach. The enrollment broker is engaged with outreach. I have had the distinct pleasure of going out with Dave in meeting beneficiaries and providers throughout the state in a number of different events. We have an entire team that is undertaking this activity. In October alone, we will be out to over 22 different engagements. Right now, there are 14 scheduled in November, and 6 in December. I encourage people to go out to the website. These events are posted. They change daily, and you can see where these kinds of activities are in your local areas. We also do have people out in each one of the DSS offices supporting those people who would like to come in, talk to someone and we actually support enrollment right there in the offices with these individuals. That way people can have their enrollments handled at that time.

There are a number of outreach materials. There are posters that you will see as you go out, especially to the DSS offices, fact sheets, there's a Q&A pamphlet, there is also a small palm card. This is designed for people to carry with them so once they have made their choice, they do not have to go to the Internet, they don't have to go back and look at the letters, they have the information they need based on one, two, three, in terms of things they need to do and it lists on the back, all of the different health plans so if they have made a choice, they have the number to connect to that health plan.

So, one of the things that we talked about is there are a lot of ways for people to get their questions answered. I think here, you can see if people have questions about eligibility, that is handled at the local DSS office, that is not the responsibility of the enrollment broker, but people can get help in the DSS offices. We have got people out there from the enrollment broker to help answer questions. If people have questions about their benefits and claims, they can call the Medicaid Contact Center. There is a toll-free number. If it is about choosing a plan or a PCP and enrolling in a plan, you can call the enrollment broker. That is 833-870-5500. If people have enrolled and have questions about their benefits, they can call their health care plan. With that, I would like to open it up to questions.

>> Thank you. We will now start questions. We have several. We will start with you, Eric.
Will they go live in February if the General assembly of North Carolina does not have a budget come November 1?

>> Thank you for that question because obviously, we needed to change the go live dates originally because there was no budget earlier in September and now we continue to need a new budget, meaning we cannot go live with Managed Care under a continuing resolution budget, which is what the current budget is for the state. So, we have been saying that we need a new budget and it has to be the right budget for our department in order to go live. We need that by the middle of November. So, we are hopeful that work continues at the General Assembly to move forward to not just have a budget that allows Medicaid to move forward but has to be the right budget that does not cut our department. This critical time of implementing, as we have been talking about this major change, is the timing. I do want to just also add that it is not as easy as a one-on-one meeting maybe by the end of November, we only lose two weeks. As we have been talking about, this is a complicated machinery of operation, so in order to keep moving forward we really do need that budget by mid-November. If we were to lose time here, the delay would be in the order of months, not weeks. But what I want everyone to hear is to keep working, keep moving forward with a February 1 date in mind and with all of the dates we talked about today. Because we do need to keep that momentum going outward even in the face of adversity.

>> Thank you. We have several people in the room to answer questions. This next one is for the Secretary of Medicaid. In the webinar last week, providers were told that many Medicaid members will be staying with their MCO's, is this correct?

>> Good afternoon. To answer the question, there are specific eligibility criteria, but generally, the way to think about it is individuals with mild to moderate behavioral health issues will go to standard plans and those with significant behavioral health or mental health issues will stay with the MPS until we go live. That includes serious mental illness and IDD.

>> Great. One more right now for you, the materials included on the website say Carolina Complete Health is only available in regions three and five.

>> If it has not changed yet, it is in the process of being changed. So obviously, there is a number of things that have to be updated, but generally, we are working through the website, the mobile phone app to get all of these items updated.

>> Thank you. Eric, if the recipient has not received an enrollment packet, who should they contact?

>> People can call in if they have not received a packet they can call in at the number that we have talked about, the 833-870-5500 number and we can make sure we get a packet out to them.

>> Thank you.

>> This goes back to the previous question a little bit. We want to confirm that the original date is November 1.

>> Correct. November 1 is not happening anymore. We will be in open enrollment for the entire state through mid-December. Nothing will go live in November. We will continue with open enrollment for the entire date until December 13 and then we will go live for the whole state on February 1, 2020.

>> Eric, people will be on the Tailored Plan, will they receive a letter?

>> Why don't I answer that? So, they referenced earlier individuals who are title plant are exempt, which means they qualify for a title plan, they will receive a letter that explains they have a choice. If an individual is on the TBI waiver, they should not be receiving a notice at this time.

>> Great, thank you.

>> Jay, will the state continue to provide fee-for-service payment to primary care providers who choose not to contract with all the health plans whenever they serve patients who are insured with one of the health plans?

>> No, in fact the North Carolina Medicaid Direct program, for those individuals who are eligible for Standard Plans, their payment, any services provided by a provider for Standard Plan members should be and must be billed to a health plan in order to be reimbursed. That is why we encourage providers to contract with health plans in order for them to continue to receive steady payments. There is a transition period where providers will be able to get paid, but that period requires them to get prior authorization and do the administrative work the health plans require. At some point, health plans are permitted to actually pay lower than the existing Medicaid rate for services provided. We really encourage providers to reach out to the health plans, go on to the North Carolina Medicaid website. We have a link to all of the phone numbers for each of the health plans. If no one has reached out to you, please reach out to them and get a contract and get it signed.

>> Thank you. In addition to legislature, training and support, will it be available for commissioners?

>> We are doing a significant amount of training for folks who are working directly with the County commissioners and associations to continue their work. We would also say if their organizations want us to come to present to their County commissioners and others in the county, we are happy to do so.

>> Can a patient change his or her plan anytime or only during open enrollment?

>> So as Secretary Cohen mentioned, that goal I will be February 1 and an individual will have until April 30, 2022 to change their plan.

>> Thank you. Do recipients mail in the enrollment packet?

>> As we receive those, we have a day turnaround time in order to process all of the applications. Our goal is to get everyone to mail them in. Prior to the deadline in the system. So, they get the plan of their choice.

>> And then a provider is interested to know, can they get an enrollment broker on site?

>> I am assuming that the provider is in Managed Care, certainly, go ahead and call the Medicaid Contact Center and we will hook you up with the right kind of information and staff to come out and help you with your issues. That number again for the Medicaid Contact Center is 888-245-0179.

>> Great, thank you. On the health plan comparison chart, it states that services may be only for members who qualify how do members know what they do and do not qualify for?

>> Good afternoon. In addition to having access to the enrollment broker to answer questions, all of the health plans also have member services staff who are available to ask questions. I think we include in the deck a list of each of the health plans and all their contact information. A member can contact the health plans to get additional information on the value-added services.

>> Thank you. What you tell staff to tell clients if none of their providers have enrolled yet or if they have a lot of specialist that care about who they want to stay with but are not enrolled.

>> We tell people two things, we tell them that providers are being added on a daily basis. We asked them to check into the website or the mobile app. It is very convenient to use to check providers and then if they do not find them there, check with their providers to see if they actually have filled out an application and so those are being processed quickly and so that way, they will know when their providers will be available.

>> We are currently a Medicaid provider; how do we know if our current contract is signed?

>> That is a great question. We were just talking about trying to create greater visibility for providers into that very thing. A couple things you can do, you can reach out to the health plan and talk to them about the process, whether or not the contract has been loaded into their system. You can also contact the enrollment broker to verify that the information is in the system. NCTracks is looking at different mechanisms to create greater visibility for providers to understand whether they have all of the information that has flowed through the various systems in order for them to be seen. But that is something, that is new functionality we are working on. My first choice would be to go to the health plan to find out if you have completed your process. You should be able to reach out to your provider relations rep or your network development specialist that you contracted with.

>> Another question around auto assignments is how do you plan to account for families? Will you be assigned to a doctor, or a practice, or a practice location?

>> So, there are two auto assignments. One is assigning health plans and the second is assigning to a primary care physician. So in assigning a family to a health plan, to reduce the administrative family cost, the potential family cost and to simplify the lustration of managing all of this care transition, we are using a familial relationship as part of our auto assignments so that we generally tend to have one health plan for

each family, though that is not a requirement, that is just the way we designed the algorithm. In terms of finding the right PPC for yourself and your family, that is something you can work out with the health plan. They will tend to assign families or individuals based on the historic relationship, but that is something you could change if you are not getting the PCP you want for each of your family members. In order to do that, you would contact your health plan after you have been assigned.

>> Thank you. There is a question, will there be training for legislative staff?

>> If we see, we are working right now to make sure we have training available and work with leadership in the Senate and House to make sure we have their legislative assistants trained so when calls come into their office, they are able to respond. We are trying to do that as quickly as possible.

>> Thank you. Eric, just confirming that all agencies have an enrollment broker on site?

>> We have got people out in the offices right now, and we will have someone, at least one person in every site by the end of the month. So, we have contacted the DFS offices. They understand who is coming, so yes, we will have them out there shortly.

>> Great, thank you. We have a few more. Can we check eligibility to see the insurance someone shows?

>> All providers should be checking eligibility before they provide services. That is just a general rule. When we are ready to go live, if the functionality is not up and running, you will be able to check tracks for an individual's eligibility and Medicaid and to understand which health plan that member has been assigned to. That functionally did not exist yet, but it is coming, and it will be available by the time we go live.

>> What does a provider to if someone comes for an appointment without their card?

>> What you should do is you check NCTracks for Medicaid eligibility. That is something that all providers should do. And then it is about finding out what health plan they are assigned to, understanding what services they are looking at and working with a member to be sure they get enrolled in the right health plan.

>> Will insurance companies furnish us a list of our patients signed up with them?

>> Sometimes that is described as accounts. It depends on the health plan. Not all health plans will provide a report or list of which members have been assigned, but some will. So, if you are a provider and that is an important feature you are looking for, that is something you should talk to your health plan about getting it on a regular basis or at a frequency that you need. Potentially, contracting or ensuring there is a contract term in your agreement with the health plan to get a copy of that panel list on some frequency that is important to you.

>> Thanks. What do DME providers need to do to prepare for the Medicaid change?

>> They will remain the same.

>> Jay, a few for you, Dual Eligible patients, when do they switch to Managed Care?

>> At this time, we intend to have dual go at a future date, undefined and that is something that will be determined later. So, we have had a robust eligible committee that worked on this before. We engage stakeholders at the same level and make sure we have that conversation.

>> Great, thank you. Will pharmacies be able to access the beneficiary’s information via the portal to bill for their prescriptions?

>> This is Jay. Pharmacies will be able to access NCTracks to understand whether or not a patient is eligible in which health plan they are enrolled with, but they will need to work with each individual health plan in order to understand additional information about that patient. That is not going to be generally available in NCTracks, that is specific to each health plan.

>> So, the hospital in this county has chosen to accept only two plans, what will this mean for the clients in our county to choose another plan?

>> This is Mandy again, so we know there are as many as 5 health plans in some parts of the state and providers may choose to contract with one or not are all. For those that contract, in this example with 2, it means they are not contracting with another two or three. What we would say is that as we go through the process of beneficiaries making choices that are right for them and their families, this is what is important for them to understand, particularly if it is a hospital they want to be sure they can get care at. So, one we would say is use open enrollment tissues those plans that your local hospital has signed up with, or we also know that networks are changing and venturing. They may sign up with two and then sign up with a third or fourth later and because we know networks are changing over this early part of Managed Care, we want to give beneficiaries a chance to change plans if they want or need to for any reason. Even though we are going live with Managed Care on February 1, as been mentioned, folks will still have another three months to change plans for whatever reason. What I would say is that local hospitals where they get care is only contracted with two, they would want to select one of the plans that is contracted with your local hospital and then if the network changes for whatever reason before those 90 days, you can make another selection. That is the process working as intended where we know that providers and hospitals will make choices about contracting and then we want to make sure that our beneficiaries make a choice that is right for them and their families.

>> Great. How many beneficiaries have already signed up and is there a report showing it?

>> This is Jay. We have had approximately 72,000 beneficiaries choose a health plan to date. We do not have a current breakout of which health plan each of those individuals have chosen and by region. So not yet. Again, we have had approximately 72,000 people actively choose a health plan.

>> Great. Will the health plan cover dental?

>> I want to introduce a concept here called a carved-out service, which is a strange name, but intentionally, dental services are not part of Managed Care and therefore, they are carved out. They are services that are provided by dentists and other professionals who participate directly with North Carolina Medicaid Direct and those professionals will continue to build their Medicaid Direct.

>> Thank you. When will Ombudsman organizations be announced and when will they go live?

>> We are currently in a silent period as we are evaluating the procurement. We anticipate that procurement will be completed before the end of the year.

>> This person says they have submitted their provider enrollment application, but have not had any response for the insurance company, should they be alarmed?

>> I would not be alarmed, but I would take action and I would reach out to my health plan that I contracted with or thought I had contracted with and make sure they received a copy of the contract and that they are in the process of loading it. Again, you should have a number of a network development specialist he worked with. If not, you can contact the health plan directly by going onto our website and using the phone numbers or links off the website.

>> Great. Can a provider be denied a contract to see Medicaid patients?

>> No, the health plans must offer you a contract and no, they cannot deny you a contract.

>> Great. How quickly does the website update when a PCP joins a health plan?

>> Thank you, there are a couple steps that have to take place after a provider has submitted their contract. The health plan needs to do a few validations of some of the information, which is just routine and then they need to go through the actual steps of loading the contract into their claim payment system, so as a provider, you have negotiated very hard and gotten the rates in the terms that you want. Now the health plan has to load those into their system. Once they have completed the process and they can pay you as a provider, they then push the information to the enrollment broker and the enrollment broker is able to display it. It is a requirement of our contract with the health plan that before they promote, before they advertise that you are in network. They have to have the ability to pay you on the next payment cycle. So that puts pressure on the health plans to load your information before they can start advertising that you are in their network. So, it does take anywhere from four weeks, potentially longer and therefore, we are recommending that providers have their contracts completed and sent into the health plans by November 15 in order to fully participate.

>> Thanks. Can providers negotiate their own rates with each Managed Care Organization or are the service right the same for all providers?

>> This is Jay. Providers, under Managed Care are able to negotiate your own rates.

>> Will the providers get copies of the enrollment forms to hand out to patients in need of them?

>> We are not mailing out those forms. If people need a form, I would have them call the 833-870-5500 number and we will make sure we get one out to them. As I said, these are unique to that person, so we can ensure the process quickly, so we would appreciate your help in referring them to us.

>> Thanks. We have just a couple minutes left. Will there be an open enrollment period every year?

>> Yes. This is Jay. For each individual, we do have an open enrollment period of 90 days at the point of redetermination. Redetermination is when a Medicaid eligible individual has to go through the process of resubmitting or validating information to verify they are still eligible for Medicaid upon completion of that period. They are auto assigned back into the plan they were with, but they do have that 90 days after assignment to change plans, so if for whatever reason they do not like the health plan they are with upon redetermination, they can choose a new health plan.

>> Thanks. We will take one final question. What is the process to change doctors after February 1 and what channels will people have to go through?

>> I will take that if that is all right. So, in order for an individual to change their PCP after they have been enrolled with a health plan, they would simply reach out to the member service line at that health plan or their care manager who is working with them and they will be able to change their PCP through that health plan.

>> Thank you. The presentation will be posted on our website. Additional resources have been provided on the left-hand side of your screen. Thank you for attending today's webcast.

>> [Event concluded]