NC Medicaid Transformation Section 1115 Demonstration Waiver Webcast

Chris Mackey

(Intro): Good afternoon, everybody. Thank you for joining us on today's call. This call is hosted by the North Carolina Department of Health and Human Services. This call is a webcast, and there's no telephone dial-in. You will need to listen through your computer speakers. Remember to turn your speaker volume up so that you can hear. If you're having technical difficulties, please use the chat box on your screen right now to describe the problem. Thank you so much.
Good afternoon, everybody. We're going to get started in one minute.

(Slide 1): Good afternoon, everybody, and thank you for taking time to join us today. I'm Chris Mackey, the director of communications at the North Carolina Department of Health and Human Services. This call is intended for stakeholders and not intended for the press.
If you're a credentialed member of the press, this call is on background and not for attribution. DHHS Secretary Mandy Cohen is going to give us a brief presentation about the state's 1115 waiver, then she'll answer questions at the end of the presentation. If you have a question, you can type it in the chat box on your screen at any time during the presentation. As a reminder, this is a webcast; there is no phone dial-in. Use your computer speakers to hear the presentation. And remember, we're going to take questions at the end. You can type them at any time, but we'll be answering them at the end. Now I'm going to turn it over to Secretary Cohen.

Mandy Cohen

(Slide 1): Well, good afternoon, everyone. Thanks for joining. Unlike for those of you who may have joined for the webinar for the RFP (Request for Proposal), we have slides this time, so do pay attention as we click through the slides, and we will post them at the end here. I'm also joined by a big team here in the room over at the Department of Health and Human Services, and Dave Richard, our Medicaid director, is going to join me in doing some of these presentations. So, we're excited about this week and to finally get the approval of our 1115 waiver. This has been a piece of work that our department has been working on well before I got here, so I want to acknowledge the work of the entire team across the department who has worked on this for many years. I want to thank you for all the work that you did to respond to our stakeholder sessions that we had and to give us some very thoughtful feedback as we adapted the waiver. So, I'm excited to walk through today where we are and then take your questions.

(Slide2): So, as we go into this second slide here, what we'll cover is just a bit of overview about the waiver's role in Medicaid transformation, then we'll go through some of the main features. We do want to talk about some of the pieces that were not included in the waiver, and then we'll take your questions.

(Slide3): And to step back here on slide 3, I hope at this point you are familiar with our vision for Medicaid transformation, and how it will improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care that addresses both the medical and non-medical drivers of health. And I'm pretty excited that the 1115 waiver that was

approved this week by the federal government really does embrace this vision and allows us to continue on the path that we have been on together and that we've been planning for.

(Slide 4): As you see on slide 4, a bit of an overview about our transition to managed care, as many of you know we have been working on this for quite some time. In 2015, the general assembly enacted a law that said we are going to move our Medicaid program and our NC Health Choice program, which is currently state administered fee-for-service program and we're going to move it to managed care. And since then, as I mentioned, lots of work has been done to continue to collaborate with all of you who are joining on the call, with clinicians, with hospitals, beneficiaries, and we've been committed to really four major components of this transition.

First is about delivering whole-person care through coordinated physical, behavioral health, intellectual and developmental disabilities, pharmacy products, and care models. We're going to talk a lot about how this waiver embraces that goal.

Second, we want to address the full set of factors that impact health, uniting communities and healthcare systems. We also want to make sure we're performing localized care management at the site of care, in the home or community. We want to maintain broad provider participation by mitigating provider administrative burden. So, the things we will be talking through today are specific to the 1115 waiver, so a lot of the details of our Medicaid transformation we're not going to go through in detail but they all fit back into those four buckets of work that we are trying to do.

(Slide 5): So, what we are focusing on today is about our waiver approval. So, in November of 2017, North Carolina did submit an amendment to that 1115 demonstration waiver application, which updated the waiver application that was submitted back in June of 2016. There are many aspects I mentioned of Medicaid transformation that are part of this waiver, but not everything. The Medicaid waiver only focuses on those things that required federal authority. Other features require federal approval but through other vehicles such as state plan amendments or the PHP contracting process. But we're excited that the approval of this waiver is a key milestone on our journey.

There are going to be, as I mentioned, a few matters that continue to be pending and we'll continue to work on, and Dave Richard will go through those, but at its most basic, North Carolina now has the authority to implement its Medicaid managed care program, but we also have some really innovative pieces of this waiver that I think are going to make North Carolina a national leader in promoting value and improving health through the Medicaid program. I also think it is important to know that we are continuing to move forward with the plans that we have laid out for Medicaid managed care, the same timelines, the same structure, we do not need to have any amendments to our request for proposals for our managed care companies, so we're still on track and marching forward in terms of meeting deadlines and marching towards managed care.

With that, I'm going to turn over to Dave Richard, who is our Medicaid director. I would like to thank Dave for his steadfast leadership on this, and he's going to walk you through some of the features of the waiver.

Dave Richard

(Slide 5): Thank you, Secretary Cohen, and let me echo how much we appreciate the team that has worked on this from across the department, inside Medicaid, and all our partners across the state. It has been truly a team effort to do that, and we're thrilled about this, and, we want to thank you for your leadership in getting us over the finish line and the vision that you set for North Carolina in terms of this waiver.

Let me just touch base on this slide quickly, we're going to talk about behavioral health integration and tailored plans, an important piece of opioid strategy inside this waiver and then ask that Secretary Cohen spend more time talking about healthy opportunities when we get to those pilots. So, we'll go to the next slide, which is slide 7.

(Slide 7): Okay. So here we go. Sorry about that, a little bit delay on that slide. What so many of you know, that we've had a long conversation about behavioral health inside of North Carolina. In the original legislation that passed in the General Assembly, we continued to carveout managed care system for behavioral health. We, along with so many of you across the state and our partners in General Assembly, worked very hard to realize the vision of an integrated system that we have been talking about for years in North Carolina. And in fact, when we did our stakeholder engagement across the state, one of the things we heard every place we went consistently was that if we're going to move, as we make the move to managed care, integrative behavioral health and physical health with pharmacy is critical to success in North Carolina.

We are so pleased that legislation passed last year to allow us to move forward and that in the 1115 waiver CMS (Centers for Medicare & Medicaid Services) recognized the importance of this and has given North Carolina permission to move forward. So, the high level of this on the slide, as you know, is that it allows for us in our standard plans, which are for the vast majority of Medicaid beneficiaries, to integrate physical, behavioral and pharmacy benefits for those people generally you would think of as having mild and moderate needs in that area. That allows us to really begin whole-person care in North Carolina, which is an incredible exciting effort, and that begins in standard plans when we go live in November of 2019.

There will be, it's important to note, inside the standard plans a specific set of benefits that are available for those members that will meet their needs as they're in these plans, and they are important that those individuals have those services in the standard plans. But we begin there. But in the conversation that we've had with people across the state, what we realized is that we had been working through a system with our LME-MCO's (Local Management Entity-Managed Care Organization) in the community-based managed care system for specialty services that we wanted to build on, like we've done inside this waiver, try to build on what's best in North Carolina to make sure that what we're moving to in managed care is a system that meets the needs of all of you, our citizens. And in that reign, we've had a lot of conversation with you and others about our tailored plan proposal, which is to create a specific plan with those people that have more significant mental health, developmental disabilities, substance use and traumatic brain injury needs that meets their

unique needs.

Clearly having a special set of services that are available for those individuals is an important component of it, but most importantly is thinking about how we support people in a different way, which means that we'll have care management through specialized behavioral health homes designed to meet the complex needs of people that have behavioral health and developmental disabilities support.

What we think is that supporting this effort will significantly change how people receive those services because now not only will we concern ourselves with the physical health, the behavioral health and developmental disability needs, but that will be integrated with the physical health, which we all know is so important if we're going to achieve the goals that we want. So, a significant milestone, I'm excited that this is included in the 1115 response, and we look forward to that work with all of you as we launch tailored plans in 2021.

(Slide 8): Another piece of the strategy that we think is very important, as you know, North Carolina has a significant issue, as so many states do, with the opioid crisis and substance use in general. From 1999 to 2016, nearly 11,000 North Carolinians lost their lives to unintentional opioid overdose, and unfortunately in 2017 alone, that number was 1,700. We know, and you know that we have to do things to address this crisis. We took advantage of flexibility in the federal waiver to think differently about our opioid strategy inside of Medicaid to help drive the kind of response that North Carolina needs to address this effort.

One of the key components of this is the ability for us to waive the IMD rule for people that have substance use needs, and I use that term, it's not a great term. The Institute for Mental Disease (IMD), but what this will allow for us is for people in inpatient settings above 15 individuals to receive Medicaid-supported services in that setting. In addition to that, we will add additional services for people that have these significant needs around opioids and other substance use as we implement the waiver.

One unique feature of this is that we begin early with some of these features, and we are hoping to launch beginning these efforts in January of 2019, which we believe will be another key piece of our global opioid strategy for the state, so we're terribly excited about CMS's approval of this work also. And I'll turn it over to Secretary Cohen to talk about probably one of the most exciting parts of our waiver, the social determinants of health.

Mandy Cohen

(Slide 9): Great. So, thanks, Dave. As you can see on our slide, we have one piece of our waiver that is related to a Healthy Opportunities Pilot. As we know, people's health is driven by more than what just happens within the four walls of a hospital or a clinic, and, you know, an example that I often give is about something that was piloted here in North Carolina in Guilford County for children with severe asthma. We know children with severe asthma often wind up in the emergency room, and we also know the emergency room is both the most expensive place to get care and it's often not coordinated. So instead of continuing to just pay for emergency room visits and the medications and the doctors'

visits, they thought differently to say, well, what's really driving that, the asthma attacks? So they went to some of the children's homes, they ripped up their carpet, gave them new carpet and gave them air filters, and what they saw was that those children got far fewer asthma exacerbations or were in the emergency room a lot less, so they were spending less healthcare dollars, their health was improved, they were back at school learning, and mom and dad were at work. So that win, win, win are some of the kinds of things that we're thinking about in these Healthy Opportunities Pilots where we can focus on what is really driving health even if it might be outside the traditional four walls of a hospital and clinic. And again, that goes back to our goal around thinking about delivering care to the whole person and addressing both the medical and nonmedical drivers of someone's health.

Now, you may have seen this pilot, we worked on this pilot for a number of months in coordination with the Centers for Medicare and Medicaid Services Team and the administrator Seema Verma did publish a blog post in Health Affairs this week that highlighted this pilot. I do think it is quite innovative and its things that we are seeing the entire healthcare industry start to figure out how to think differently about health overall, and I think this is going to give us a great opportunity to learn and be a leader in the country on how to do this right.

So, with this Healthy Opportunities Pilot, in two or four regions of the state, again, we have not chosen regions yet, but we expect for this to be in two to four regions of the state. Our managed care plans are going to work with local communities to address their more vulnerable Medicare enrollees in about five areas of need: housing, food, transportation, employment, and interpersonal safety. Plans will identify Medicaid enrollees that can most benefit from these kinds of interventions, just like they would identify kids with severe asthma, for example, and then pair them with some cost-effective and evidence-based interventions that are available within their community. So again, target asthmatic kids, and they would target them with an evidence-based intervention like replacing their carpet and giving them an air filter.

And then care managers that are embedded within the managed care system as well as within our practices and within the whole managed care system are going to be working closely with beneficiaries to make sure that those services are efficiently delivered.

Certain features of the pilot that were approved in the waiver ensure that our state and our federal dollars are really being used efficiently and effectively as possible. Over time, those payments made for those kinds of pilot services that I was mentioning, services like that carpet replacement, will be increasingly linked to outcomes, to improvements in enrollees' health, because that's what we all want, right, to buy health. Additionally, North Carolina has designed a rigorous evaluation strategy and is going to be implementing rapid-cycle assessments to gain insights into the impacts as we go. This is very much a learning activity. We really want to know what are the right tailored activities that can really drive health and reduce costs, and in real-time, working with community partners. We're going to be modifying this initiative over time. If we see something working better, we're going to move towards it. It we see something not working, we'll move away from it. And those real-time course corrections are going to enable us to ensure dollars are being used wisely to benefit North Carolinians.

To put this in some context, CMS has not previously approved the demonstration that tackled such a

broad range of factors affecting health or that puts these health-related factors in front and center of delivering care. As I mentioned, this really does put North Carolina on the leading edge of promoting value and improving health through its managed care program, and I think that's why Administrator Verma this week highlighted it in a blog post for Health Affairs.

And we have an ambitious agenda. We are going to need to do a ton of work to implement this well. To learn the lessons from this pilot and do it successfully but achieving federal authority to do this was a major milestone, so we're pretty excited about this first step. We know it is only a first step, and so stay tuned for a lot of additional details as we work on rolling this pilot out, doing it successfully, again, to drive better health and smarter spending for the Medicaid program.

With that, I'm going to turn it back over to Dave to go through a couple last details, and then we'll take your questions.

Dave Richard

(Slide 10): And just as exciting for everyone, I'm sure, budget neutrality, we want to touch base on. Budget neutrality is sort of a CMS conversation that we have, and it is really a technical part about the waiver as we go forward. The federal government, when we do an 1115 waiver and all of our waivers require that they are budget neutral. What that really means is that we do not increase spending beyond what state and federal government projections would have been without the waiver. It is a technical process that we spent a lot of time on with CMS and incredible work by our staff of pulling together that information to make sure that North Carolina got the right deal as we move forward. It's not a small pulling, because it did consume a lot of time, but we're pleased to announce that CMS has agreed that the waiver will not increase North Carolina's Medicaid spending for these populations and services authorized under the waiver.

(Slide 11): We'll also mention another thing that actually is exciting beyond the budget neutrality clause, it's our evaluation strategy. I say that because the 1115 waiver requires, because it is a demonstration waiver, that we evaluate whether the things that we are testing actually do work and how they work. So, like all other 1115 waivers, we'll have a rigorous evaluation of the full waiver beyond just the Healthy Opportunities Pilots to measure its impact. It will be done by an independent evaluation conducted by a third-party, the entity, and we'll produce two publicly available reports over the course of the five-year demonstration, but a critical component of an 1115 waiver.

As we discussed in the conversation about the length of time that the waiver took to be approved, and that's because there are an awful lot of details. And although we're pleased with what has been included in the waiver, there are items that we will continue to discuss with CMS and items that we have gone to CMS with and they're just not going to approve. So, let me talk a little bit about the items that we have pending for further negotiations.

(Slide 12): We have a vibrant tribe, the Eastern Band of Cherokee in North Carolina, who have been doing some really incredible work around healthcare. And throughout the waiver process, we've been talking to them about ways in which this waiver will help the tribe improve their services to tribal members and make a difference. One of the items that we wanted to include was an uncompensated

care pool for tribal providers. We wanted to help them strengthen their providers and ensure better access to tribal members. What this pool would have done is allow them to address the higher burden that they have in the Cherokee Indian Hospital Authority by uncompensated patients.

We had vigorous conversations with CMS about this, and at the end we were not able to convince them to include it in the waiver, but what we have said is that we need to continue these conversations. This is a very important component for the tribal members and for North Carolina citizens with the work that they're doing, and we'll continue to have that conversation.
We would also ask CMS to help us with some workforce issues. We all know that without a high-quality workforce in healthcare and in health across North Carolina, that the objectives and goals that we're trying to meet will be much more difficult to do so. So as such, we asked them to invest in a provider network by incenting participation and ensuring beneficiaries have access to these provider types. In the waiver itself, they did not approve our request, but we will continue to work with CMS on those goals outside of this waiver process.

And then we asked a very technical question for CMS. We have had behavioral health home payments in our state. We're going to -- excuse me, health home payments in our state. We're asking in the waiver that we be allowed to do specific health home enhanced payments for those health home providers. We would ask CMS to allow us to do a prepayment or work ahead of time to help with the infrastructure for behavioral health homes. We were not able to come to an agreement of that in our negotiations, but we will continue to work with CMS to see if we can secure additional funds for that and that we can do those early payments to providers to allow for that infrastructure development.

And then there are certain things that they did not approve at all, and although we're disappointed in that, we want to mention those. They did not approve our telemedicine initiative. It does not mean that we won't have telemedicine inside the waiver. I want to be clear about that, but that our initiative to add support for our work in telemedicine beyond our ability to pay providers was not approved by CMS. They also did not approve our approach for certain wrap-around services for safety net providers, but I want to assure people that that doesn't mean we're going to abandon safety net providers. We will still pay providers, it will just be a different way in which we'll do that. And for covering, we mentioned that the SUD IMD (substance use disorders) exclusion is addressed in the waiver. We had asked originally if we could do so for mental health services, but we were denied that in this effort. So, we said that although disappointed in that, we're looking forward to our continued work and hope that we have the opportunity to revisit these issues in the future with CMS.

Mandy Cohen

And Dave, if I could put a finer point on it because I think there's been some confusion as I've heard folks start to talk about our waiver, there's really three buckets of items within our waiver. There are the things that CMS said yes, go forward with them, those are the things like behavioral health integration, the opioid component of the waiver, and the Healthy Opportunities Pilot. Then there are some things where they said not yet, right, we need to continue some dialogue about, I think those are what you see in the slide. Not yet for the tribal providers uncompensated care pool, not yet on workforce, not yet on the capacity building funds.

The other not yet that we should include is related to Carolina Cares. I think that is the piece of the waiver where we ask CMS for the ability, if the General Assembly did expand Medicaid, could we impose some of the requirements that were contained within the Carolina Cares bill. So, I want to be clear that within the 1115 waiver, we never asked can we expand Medicaid. That was not a question that was asked in the 1115 waiver. In fact, we don't need 1115 waiver approval for a Medicaid expansion. That is a different type of authority that we would ask CMS for. What we did ask in the 1115 waiver to say if the General Assembly in the state was to expand Medicaid and expand eligibility, could we impose some of the requirements that were contained within the Carolina Cares proposal. Those had to do with community engagement or work requirements and with paying premiums. CMS, again, put it in that bucket with these things of a not yet. It wasn't a no, but it wasn't a yes. So, we have the yes bucket, the not yet bucket, and then in the no bucket I think are some of the things that Dave was mentioning around telemedicine and our approach to wrapping Medicaid managed care payments for some of our safety net providers as well as covering some of our acute behavioral health services in an IMD.

(Slide 13): So, there were some things that were squarely in a no bucket. Luckily those were small in the grand scheme of what we were asking for, so we are on whole very pleased, I think, where we came out with the 1115 waiver. I think it very much allows us to move forward with the vision that we have set out for Medicaid managed care and link it together with all of the pieces that don't need 1115 waiver authority and allow us to move forward. So, I just wanted to put a finer point on that because there is some confusion about the things that got a yes, the things that got the not yet and need more discussion, and the things that did get the full no, if you will.

Okay. With that, I'm going to turn it back over to Chris, and then I think we'll take your questions.

Chris Mackey

(Slide 13): Terrific. Thank you. Remember, if you've got questions, type them into the chat box on your screen right now. We do have a few questions to get us started, so we will start.

Question: Will an ombudsman be appointed to oversee the private insurance and the PHP's to investigate any compliance or complaints by consumers or providers?

Mandy Cohen: Thanks for that question. And yes, as we laid out in the request for proposals related to managed care, there will be an ombudsman. All of those details are laid out here. I don't think there's any details related to our 1115 demonstration authority related to the ombudsman, but we would be happy to direct you to those details that were included in the request for proposals for the managed care entities to respond to.

Question: Will plans need to amend bids to conform with the waiver as approved?

Mandy Cohen: The good news is no, there will be no amendment. We're lucky to have pretty good line of sight in where we thought we would end our negotiations with CMS, even though it did take us a few more weeks to get to the finish line here, but the team did an excellent job of sorts of forecasting where we would be, and the good news is we do not have to amend the RFP. We did get

all of the submissions in as of last Friday. We put up an announcement, you could see the eight organizations that have submitted to compete for that request for proposals and to be partners in this Medicaid program, so we're moving forward with that, but no, no amendment needed.

Question: *W*hat will be the effect on people that are on the IDD waiver who have Medicare as their primary coverage and North Carolina Medicaid as their secondary?

Mandy Cohen*:* Let me start there. I think the first thing to know is that a lot of what's going to change in managed care will not change for folks in the waiver. The first changes that folks will see in the Medicaid program are related to folks who will go into what we're calling standard plans, who mostly are the kids in our program and the moms in our program that don't have a more extensive need for an array of services. And then we will continue to do some policy work over the next number of months to flesh out the details of sort of the next steps of phasing in populations into managed care. Now I'm going to turn it over to Dave if he wants to add any more details to that.

Dave Richard: Yeah, I think the one thing is that if you are on an Innovations waiver, regardless, that you will not move to managed care until the tailored plans go live. So that's the glide path which we're anticipating in July of 2021.

Question: Why was the waiver so delayed in getting approved?

Mandy Cohen: Yeah, we ask ourselves that a lot. We were joking, one is, you know, healthcare is complicated. I don't mean to laugh about that, but I think all of us on the phone know how complex some of these issues are and the details really do matter to people's lives, so I don't mean to make light of it. The details matter both to the state so that we can be good stewards of the resources here, as well as to the federal government. They wanted to make sure they had a lot of detail and a lot of line of sight into what we were doing and that we were going to be good stewards with taxpayer dollars. A lot of time was spent on, as mentioned, our budget neutrality model that has a lot of assumptions and factors in there that we wanted to make sure got captured, that we have a lot of unique circumstances here in North Carolina that we wanted to make sure got captured in that model, then there were some important pieces of the work that we were working through.

I think you can see by the fact that we have some things that we could not yet get yes on, that at some point we just had to say, okay, we will keep those items open and we need to get to a full yes on the majority of things, which I think we did here. And even with saying that the waiver is approved now, we still have more work to do here, and we will continue to be transparent and go through those conversations with CMS.

Question: Can an individual be enrolled in both a standard plan and a tailored plan simultaneously?

Mandy Cohen: The answer is no. You will be in one or the other. There may be a circumstance in which someone who is in one of those plans need to switch to the other, so if someone is in a

standard plan and then it becomes necessary that they need the expanded array of benefits that exist in a tailored plan, there would be a process by which we would go through to move someone from one to the other, but at any one time you would be in one place or the other, either in a standard plan or the tailored plan.

Question: One pilot per region?

Mandy Cohen: That's not correct. The pilot will not be statewide. There will be pilots in two to four regions of the state, and I think we still need to do some work to define what exactly that means. It will be a process of us both understanding what communities and what entities are interested and able and want to be partners in this, as well as with our managed care map as it evolves through the RFP process. So, we have not defined those yet, but it would be these two to four regions, but it will not be statewide.

Question: Will this initiative address homelessness, which is such a driver to poor health, both physical and mental?

Mandy Cohen: Thanks for that comment, and we recognize that housing is a really critical piece to someone's overall health, and there are a number of housing interventions that will be part of this pilot. As many of you have worked in the Medicaid space for a long time, there are some places that Medicaid dollars cannot be spent on housing, and our waiver was sensitive to those components of the law. But I think that you will see as we move through this pilot that there will be housing interventions that will allow us to help folks, you know, drive to better health. I think that we are seeing a number of evidence-based studies to show that focusing on housing stability really does drive down ED utilization and admissions to the hospital, as well as improvement in overall health outcomes, so that is exactly what the pilots are going to be focusing on.

Question: When will the contract be awarded to a payer?

Mandy Cohen: The contracts will be awarded in February of 2019.

Question: Will reducing Medicaid expenditures over time be a part of the desired outcomes? How will capitation rates be set and evaluated?

Mandy Cohen: Great question, and we're hoping that we know that great work is going on in the Mecklenburg area on this, and in terms of those pilots. Yes, the focus is going to be on improving health outcomes and reducing costs, and all of the types of interventions that we've negotiated with CMS are evidence-based interventions that have shown those positive outcomes in small studies. We want to take this to scale and learn that in larger regions, both urban and rural areas of our state, so that we can understand how to best help folks stay well and drive to better health.

Question: Does budget neutrality include allowances for population growth and conditions on the ground?

Mandy Cohen: Thanks for that question. So, in terms of budget neutrality, again, when we negotiate that with the federal government, we are negotiating basically two trend lines. One is a trend of what would we have spent if there was no waiver, and what would we spend if there is a waiver. And the caps are defined per capita. So, if we have more people, it will grow with population growth. But there were a lot of details that sort of go underneath that, and we're happy to walk you through some of those details as needed.

Question: What constitutes behavioral health home?

Mandy Cohen: Great question. So behavioral health home, I'm going to send this over to Dave because this is his baby, but essentially we want to make sure that the care coordination is essential to how we think about whole-person care, and we know that we've been driving toward a system to want to integrate physical and mental health, and we know that those with higher mental health and developmental disability. TBI needs also have a higher need for care coordination, and this is where the behavioral health home comes in, so it allows us to get some additional money to invest fast in the care coordination space. CMS did say yes to that component of our waiver, so we're going to be able to act on that.

What we did not get approval for was to pull some funding forward to think about capacity building. We know that it takes resources just to put the infrastructure in place related to health homes. That, we did not get approval for, though we're going to continue to try to work with CMS on that item. But Dave, anything else to add?

Dave Richard: I would add that we are continuing to work on design for how that will work, but the Secretary was absolutely right on the points of where we're trying to go, is that we believe that that care management function in community-based setting is a critical part of assuring that the services for people with IDD and behavioral health needs get met, because of the complex needs that those individuals have. So, as we're working through our design effort, we will engage stakeholders vigorously in that conversation.

Question: I just want to confirm that all Medicaid managed care plans will follow the same formulary.

Mandy Cohen: You are correct, there is going to be one statewide formulary for all managed care plans across the state.

Question: Will the PHP's be required to provide FDOH screening in the regions not in the pilot, or will this be optional?

Mandy Cohen: That's a great question, and this speaks to our larger Healthy Opportunities bucket of work, and while we talked about these pilots here today, there are elements built into the whole managed care transition to make sure that we are driving at smart spending and healthy outcomes. So, the more specific answer to your question about the social determinants questions, yes, that

managed care companies are going to be required no matter whether or not they're in the regions of the pilot or not. They're going to be required statewide to be administering the social determinants screening questions related to food, housing, transportation, and interpersonal violation, so that is something we're embedding across the program. We think it's an important piece of information for us, I will say for me to have as a physician, for the insurance companies to have to better manage care, so that is going to be something embedded across the whole program. Even though the pilot, which will allow us to test out additional service interventions, that will only be in a few regions of the state. We do have components of that work that will be embedded into the larger managed care program.

Question: Great. From Betsy Callahan from NHRMC, where can we see those who submitted proposals?

Mandy Cohen: Thanks, Betsy. The web -- I'm going to have someone else tell you the exact website, but on our website, the Medicaid transformation website, we have a posting of the eight entities that have submitted proposals to the State. Maybe we'll put the address in one of the chat boxes so that everyone can see it.

Question: Will people be forced to change to another doctor's practice, or will they still have a choice?

Mandy Cohen: That's a great question. The short answer is that as we start to move through the managed care process, there will be a lot of new things that our Medicaid beneficiaries will have to do. So right now, when someone joins the Medicaid program, there is an eligibility process, and once you're eligible, there isn't a second step. But as we move into managed care, folks will now not just be assessing eligibility, they'll have to enroll in an individual insurance plan. And when they enroll in that insurance plan, we are going to want them to be aware of the network that that insurance company has. So, is my doctor covered by a particular insurance company that's within Medicaid managed care? So, there's going to be a lot of work needed to help everyone understand what doctors and what hospitals are within each individual insurance product. So that will be, you know, I hope everyone will work with us on that communication effort because it will be a new step for folks. But what we are hoping is that we will have enough information that patients will be able to know where their doctor is in terms of what plan, and then they'll be able to make good decisions for them and their family about what plan best suits them.

Question: When you launch Medicaid MCO, is Carolina Access/AHM program, will it go away?

Mandy Cohen: Thanks for that question. The answer is no. So, when we launch managed care, Carolina Access program will sort of get absorbed into the advanced medical home program. So, if you're a Carolina Access 1 or 2 practice right now, you will become an advanced medical home tier 1 or tier 2 practice, which means you will continue to get the PNPN payments that you do now for some of the medical home functionality.

The new part of the advanced medical home program is the tier 3 component where we're hoping hospital systems and larger physician practices and others will consider taking on not just the Carolina Access medical home responsibility but go even further to take on the care coordination responsibilities for their entire Medicaid population, so not necessarily just the population assigned to

any one managed care company. So, we are hoping that a number of practices will want to take on the responsibility of doing that care coordination, they will not be required to contract with CCNC to do that, but CCNC will certainly be one of the organizations that folks could use to do some of that care coordination service. So there's a lot of technical assistance and other education that is going on right now to help practices and health systems understand what becoming a tier 3 medical home would mean for them, and we certainly hope to see a lot of folks move in that direction because I think getting care coordination as close to the practice as possible is going to be both better for the patients and better for the practices. So, we hope that as many folks as possible are taking a hard look at what it would mean to be a tier 3 practice.

And that doesn't mean doing it alone. We know that practices may need to partner with other practices in what we call clinically integrated networks to do that work, but this is the time to start to dig into those details. Join us for many of our technical assistance sessions and education sessions and start to dig into the details here on what it would mean because I think this is a really important moment in time to really think about what is going to be best for practices and patients overall.

Question: Who is going to educate parents about the changes?

Mandy Cohen: I'm so glad that you joined this call because I wish every one of our -- well, this is a little technical, so maybe not everyone to join for this call, but we are appreciative that you're tuning in and understanding the details here, as we are very much thinking about how do we communicate so that everyone understands all the changes that are happening. So, we have a team of folks here who are thinking about that every day and how we can do that better, as well as working with a number of stakeholder groups. We made sure to have a mom whose family is on the Medicaid program at one of our recent all-staff meetings related to Medicaid transformation because we wanted them to hear directly about what was happening in her family's life and to make sure that our work was tailored to what her family needed. So, it's very much at the top of mind for us to make sure that communication goes well, and stay tuned, and thank you for tuning in. Please do continue to give us feedback on how we can improve.

Question: When Medicaid managed care launches, do we need to reenroll providers with the MCO plans, or do we have to enroll in Medicaid first, NC tracks and then report to the MCO?

Mandy Cohen: I didn't understand the question, so I'm looking over to the smarter people in the room, Dave Richard and others, and see if they want to answer.

Dave Richard: So, others might jump in on this, but one is that they will have to have a contract with the managed care organization. Our goal is to have enrollment in the Medicaid program, credentialing, a centralized process where everybody goes through one system and that gets pushed down to the managed care plans, and then the managed care plans will wind up contracting with providers at that time. But a centralized enrollment process into Medicaid.

Question: Will there be a standard list of benefits for the standard plan and the tailored plan, or will the benefits vary based on who the managed care provider is?

Mandy Cohen: Thanks for the question. There is a standard set of benefits for the standard plan and the tailored plan, and they have to conform to currently what Medicaid covers. Currently right now if you're interested in seeing what tailored plan versus standard plan benefit covers, that is in our RFP, which is posted online. There are opportunities for plans to propose back to the State some types of in lieu services that could vary things, but we would have to agree that those are still providing the same level of service and meeting the intent of what the benefits are at this point in time. So, we don't want to say absolutely no there couldn't be any changes because we do want to give managed care plans flexibility to show us that there could be other ways to approach things, but generally they're going to be the same set of services.

Question: How many PHP vendors will be approved?

Mandy Cohen: Okay. So that was defined earlier in our RFP process. So, we're going to be selecting four statewide plans, and then on the regional plans, we have defined that we would choose up to one in Regions 1 and 6, and two in Regions 2, 3, 4 and 5. More details on that are of course in the RFP that is again posted on our website.

Question: Will there be a more seamless process for mental health providers to provide services to Medicaid consumers who seek out their services regardless of whether the provider is an in-network provider or not with the MCO LME?

Mandy Cohen: So, there's a couple of things to tease out in that question. So, let me start with the standard plan, and again, I think it goes back to this earlier question about contracting. So, providers will need to contract with the new managed care entities within the Medicaid program. The managed care companies have to meet requirements to build that network. They need to have a certain number of providers in that network, so then they would have in-network providers and out-of-network providers, that goes for physical health as well as behavioral health, so they will be undergoing that process and that contracting process over the next year ahead of managed care launch, and frankly sooner than launch date.

On the tailored plan side, we again are still developing policies around the tailored plan related to network and such, so I say stay tuned in terms of policies for network adequacy related to tailored plan.

Question: Will there be appeal rights for beneficiaries who do not agree with their initial benefit placement standard versus tailored?

Dave Richard: This is Dave. Appeal rights is probably the wrong word. I think there's always an ability for people to say that I would like to be in a different plan and we will do the assessment process to make sure that they are assigned to the right plan. So, what we are trying to achieve in this transition is to make sure that all beneficiaries, all have the appropriate plan that is designed to meet their needs. So yes, an opportunity to request to be in an assessment would allow that to happen.

Mandy Cohen: Great. I think we just received the signal that I think we've run through all the questions. Those are a lot of really good questions. I really appreciate everyone taking the time to type those in and stick with us through this hour. Again, an important milestone achieved this week, but really just one in many series of milestones that we'll continue marching along to achieve our vision of where we're headed with Medicaid transformation. Again, thank you for tuning in, for your partnership, for continuing to give us feedback. I'm sure we will be talking again to you soon.

Chris Mackey

(Slide 14): Thank you very much. If anybody wants to get any more information, one place that you can go is the DHHS website at NC -- and this is long, hang in there with me for a second – ncdhhs.gov/assistance/Medicaid-transformation. And this is going to be archived. So, thank you very much for joining us. Enjoy the rest of your day.