Medicaid Transformation

1. Q: Is there a link to NC DMA Medicaid Transformation site with information on standard and tailored plan implementation?
   A: Yes. Please find this information at the following link:
   https://www.ncdhhs.gov/assistance/medicaid-transformation

2. Q: Can Alliance revise the Care Team graphic to place the member at the center?
   A: We will take this feedback into consideration should we revise the current graphic.

3. Q: Will my current healthcare provider need to enroll in Alliance's Network in order for me to continue to receive their services?
   A: Once the Tailored Plan goes live in July 2021, yes. Alliance will be contacting all local Medicaid physical health providers to request interest in joining our Network prior to July 2021.

4. Q: How will individuals on the registry of unmet needs (waitlist for Innovations Waiver) be served by Alliance once the Tailored Plan is implemented?
   A: Every individual enrolled in the Tailored Plan (this includes individuals on the registry of unmet needs) will have access to a Care Team.

5. Q: Do we have a choice about going to a tailored plan?
   A: All Innovations and TBI waiver participants will be automatically enrolled in the tailored plan. Only the tailored plan benefit package will include Innovations waiver services.

6. Q: What does Alliance have to do with my physician?
   A: Alliance will manage your physical healthcare services under the tailored plan (anticipated to begin in 2021). Your physical healthcare providers will need to contract with Alliance once the tailored plan goes live.

7. Q: What if my doctor or pharmacy doesn't want to join the Alliance Network?
   A: An Alliance representative will speak with you about service options in the event your doctor does not elect to join our Network.

8. Q: Will Alliance be managing Medicare under the tailored plan?
   A: No. The tailored plan will only cover Medicaid services.

9. Q: How will Medicare and Medicaid (Alliance) interact under the tailored plan in 2021?
   A: Alliance will have a Medicaid contract, but we will be able to see claims and explanation of benefits (EOBs) from Medicare.

10. Q: Will allied health (such as Physical Therapy, Occupational Therapy, or Speech Language Pathology) be covered under the tailored plan in 2021?

A: Yes. Physical health, behavioral health, and pharmacy services will be covered by the tailored plan anticipated to begin in July 2021.

Care Teams

1. Q: Where is funding for additional Care Team positions coming from?
   A: Alliance has not received any additional funding for the new Care Team positions. We have repurposed existing positions to support the new Care Team roles. Eventually, Alliance will receive an increased payment to hire additional Care Team members needed for tailored plan implementation. Additional funding will become available for positions for physical health care management if Alliance is awarded a contract to operate as a Tailored Plan.

2. Q: Can I keep my Care Coordinator that I have now?
   A: Every Care Coordinator has been assigned a new role on the Care Team. Some Care Coordinators have been assigned to the role of Care Navigator, who will be the central point of contact for the member/family and in charge of plan development and facilitating communication with the Care Team. We will take the current caseloads of those transitioning to the Care Navigator role into consideration when finalizing case assignments.

3. Q: Why are Care Teams starting in July 2019? The tailored plan doesn't go live until July 2021.
   A: We want to ensure that we afford ourselves the time to work out any challenges associated with using the Care Team model and refine our approach prior to Tailored Plan implementation.

4. Q: Will my current Care Coordinator be able to tell me what their new Care Team assignment is and explain the reasons they decided to change roles?
   A: Yes.

5. Q: What training will be provided to assure Care Team members are knowledgeable and ready to start their new roles?

   A: Each Care Team member will be trained on how to perform the duties required of their role. Prior to role appointment, we reviewed customer satisfaction surveys to learn about each Care Coordinator's strengths. Those survey results helped inform what roles each team member will be best-suited for.

6. Q: Will self-direction/Employer of Record (EoR) continue to be an option under the new care team model?
   A: Yes. The Care Team model will not impact the services made available through the Innovations Waiver.

7. Q: Who will my main point of contact be on the Care Team?
   A: The Care Navigator will be the central point of contact for the member and their family. The Care Navigator will be available to receive your updates, assess your needs, develop and make updates to the plan of care, and provide education on available service options.

8. Q: Do I have to have all the members of the care team at my home during the annual plan meeting?

A: The member/legally responsible person decides who will be allowed to attend the annual plan meeting. The only Care Team member required to attend is the Care Navigator, as they will be in charge of writing the plan.

9. Q: Is it possible for the Care Navigator to meet with us more than just once a year (for the annual plan meeting)?
   A: The Care Navigator can meet with you as frequently as needed. We encourage you to discuss the level of face-to-face contact needed with your Care Navigator.

10. Q: Who on the Care Team is responsible for identifying an alternative group home placement?
    A: The Care Navigator.

11. Q: Will a Provider Network Consultant be assigned to each provider?
    A: Yes.

12. Q: What will Alliance's interface look like with physical health providers?
    A: If needed, the physical health consultant will contact the member's physical health provider or pharmacy to resolve care concerns or barriers related to accessing physical health services.

13. Q: Will there be multiple Provider Network Consultants assigned to the Care Team when there are multiple providers involved?
    A: It is very likely that there will be more than one Provider Network Consultant assigned to cases where there are multiple providers involved in treatment. Provider Network Consultants will have a caseload of providers, assigned by provider and service region.

14. Q: Will requests for Durable Medical Equipment (DME) be the responsibility of Tailored Plans in July 2021?
    A: Yes.

15. Q: Will disaster planning be the responsibility of the Community Health Worker?
    A: The Community Health Worker will coordinate disaster preparation in concert with the Alliance Community Health and Well Being Department and the Alliance Disaster Response Team.

16. Q: When will members be notified about Community Navigator assignments?
    A: We are planning on mailing notification letters to members on 6/21/19. The assigned Care Navigator will contact the member after that point to introduce themselves.

17. Q: When will providers be notified of Provider Network Consultant assignments?
    A: The Alliance Provider Networks Department will notify Network providers as soon as case assignments are made (anticipated completion date: 6/21/19).

18. Q: How will Care Navigator caseloads be determined?
    A: We will use a risk stratification tool to determine the level of support each member needs. Once this occurs, the case will be assigned to a Care Navigator who has the education and experience required to address that individual's needs.

19. Q: Who will supervise the Care Team Members?

A: There will be supervisors assigned to oversee the activities completed by each individual on the Care Team.

20. Q: Are other MCO's implementing a Care Team approach?
    A: Every MCO operating a Tailored Plan will need to provide an approach to care management that supports whole-person health. This will look different than the model of Care Coordination used today, and may differ between MCO's.

21. Q: Can my current Care Coordinator tell me what their new role is and why they selected their new Care Team role?
    A: Yes.

22. Q: How will we introduce a new team of people to individuals that may not adjust well to change due to their diagnosis?
    A: The Care Navigator will be the primary connection to the member/family. The Provider Network Consultant will be present for monitoring services. Other members of the Care Team will be assigned as needed and will typically only assist for a limited time (i.e. until a presenting issue is resolved). Families will always be able to provide input on how a new Care Team member should be introduced and how much interaction they would like to have with those team members.

23. Q: Why is there the need for so many Care Team members to be involved on one case?
    A: Every Care Team will consist of a Care Navigator (central point of contact for family and plan developer) and a Provider Network Consultant (monitors services in home and community and supports the provider to ensure outcomes are met in plan of care). Other members of the Care Team will be assigned as needed, should consultation be required in one of the following areas: behavioral health (higher level of care is needed or assistance developing engagement strategies), physical health (review of medications/MD orders, and consultation with physical health providers to address member health needs), and social services (housing, transportation, access to health food, safety, employment, and education), community inclusion, and benefits assistance.

24. Q: Who is the member's primary point of contact on the Care Team?
    A: The Care Navigator.

25. Q: Please clarify the letters I will be receiving.
    A: A letter will be mailed in June from Alliance, which will inform members of their assigned Care Navigator. The State will send a separate letter to members to select a standard plan starting in November 2019.

26. Q: Who will help with obtaining prescriptions for DME, consultants, or supplies?
    A: The Care Navigator will coordinate all service requests and requests for supplies.

27. Q: Can we still choose providers for Innovations services?

A: Yes. This will not change.

28 Q: Can Alliance provide examples of other states that are using a behavioral health interdisciplinary care team model?

A: Please see paper, *Community Care: An Overview of State Approaches* (prepared by: Center for Health Care Strategies & State Health Access Data Assistance Center) at the following link: https://www.chcs.org/media/Community-Care-Teams-An-Overview-of-State-Approaches-030316.pdf