NC InCK NC INTEGRATED CARE FOR KIDS

NC InCK Family Navigator Tip Sheet: Transitions to a Tailored Plan

What is a Tailored Plan?

Tailored Plans (TPs) are a type of North Carolina Medicaid plan that will provide the same health care services as Standard Plans (SPs), plus additional services not covered by Standard Plans. These additional services include:

- Enhanced behavioral health services
- Pharmacy services
- Long-term services and support
- Services to address social determinants of health
- Services for mental health disorders, substance abuse disorders, intellectual/developmental disabilities (I/DD), or traumatic brain injuries (TBI)

Tailored Plans are expected to launch in 2024.

Until Tailored Plans launch, individuals meeting eligibility requirements are designated as "TP-Eligible" and are in Medicaid Direct. Their behavioral health services are managed by Local Management Entity-Managed Care Organizations (LME-MCOs), which will later transition to Tailored Plans.

TP-eligible members qualify for Tailored Care Management (TCM) services, where a lead care manager, supported by a multidisciplinary team, coordinates care for members' behavioral, physical, and social health needs.

Alliance Health and Vaya Health are the two LME-MCO/Tailored Plans available to NC InCK members. Members' LME-MCO assignment depends on their county of residence:

- **Durham and Orange Counties:** Alliance Health
- **Alamance, Granville, and Vance Counties:** Vaya Health

Who May Benefit from the Transition from Standard Plan to Tailored Plan Medicaid?

One or more of the following events or situations may indicate a Medicaid recipient could benefit from Tailored Plan enrollment:

- Two or more behavioral health-related hospitalizations within the past two years
- Prescribed psychotropic medication
- Severe behavioral health, intellectual, or developmental disability needs
- Emergency Department (ED) visit for a suicide attempt
- Receipt of behavioral health services (e.g. outpatient therapy, psychiatry services) for an extended period of time (six months or more) with little or no improvement

How Can Family Navigators Talk with Families About Tailored Plans?

If a child or adolescent you are working with meets the criteria described above, it may be beneficial to discuss the transition of Medicaid benefits to a Tailored Plan. Here are some questions to consider when helping a member or guardian determine whether the Tailored Plan is right for them:

- Are the member's behavioral health needs being adequately met with current behavioral health services?
    - If yes, consider continuation with the current health plan
- How long has the member received behavioral health services?
    - It may be appropriate to stay in the SP if the member has recently started behavioral health services. It often takes 3-6 months of behavioral health treatment such as therapy and/or medication management for symptoms to improve
- Can additional behavioral health services be added to their existing health plan?
    - If yes, explore alternative behavioral health treatment options within the current health plan prior to TP transition.
- Does the member have a documented behavioral health diagnosis and treatment recommendations that are not covered by the Standard Plan?
    - If yes, consider transitioning to TP

What Is the Process to Request a Transfer from a Standard Plan to a Tailored Plan?

Family Navigators should first view the Medicaid Fact Sheet on Tailored Plan transitions. The Non-Service Associated Requests section on Page 2 of the fact sheet details the process for beneficiary transfer requests. Family Navigators can use the process below to support a member requesting a transition to the Tailored Plan.

Medicaid beneficiaries can complete requests to transition from Standard Plans to Tailored Plans using the transfer form link below, or by calling the enrollment broker to request a transfer form by mail. Care managers can provide support by completing the transfer form with families, or by calling the enrollment broker with families.

Online Transfer Form

Locate the appropriate form using the drop-down menu here.

A care manager can assist the family in filling out the online "Request to Move to Medicaid Direct (Fee for Service) or LME-MCO: Beneficiary Form." The care manager can gather all the information required to fill out the form prior to meeting with the family. Once the form is signed, it can be submitted by mail, fax, or online.

Mail:	**Fax:**	**Online:**
NC Medicaid PO Box 613 Morrisville, NC 27560	1-833-898-9655	NCMedicaidPlans.gov

Enrollment Broker

Families can ask questions about the transfer process, or request the transfer form by mail by calling the Medicaid enrollment broker at 1-833-870-5500, Monday through Saturday 7 a.m. to 5 p.m.

What Happens After the Request to Transfer Has Been Completed?

Once the transfer form is received by the enrollment broker, beneficiary forms are reviewed within eight days. If approved, the member is enrolled in Medicaid Direct-Tailored Plan Eligible on the first day of the following month. The beneficiary will receive a notice with NC Medicaid Direct enrollment information and an NC Medicaid Direct ID card.

If the request is denied, the beneficiary will receive a letter of notice informing them of their appeal rights.

To check on the status of a Tailored Plan transition request, the member or guardian can contact the Medicaid enrollment broker at least 24 hours after the transfer request form is submitted by calling 1-833-870-5500, 7 a.m. - 5 p.m. Monday – Saturday; TTY: 711; or online at RelayNC.com.

Family Navigator Tip: To ensure a member is linked with Tailored Care Management (TCM) upon transfer to the Tailored Plan, complete a warm handoff with the TCM care manager. This handoff should include providing accurate contact information for the family, sharing the Shared Action Plan and NC InCK Consent, and a phone call with the TCM. Family Navigators or families can contact the appropriate LME-MCO member support line below for an update on TCM services for new members.

Contacting the LME-MCO/Tailored Plan entity after a transfer is approved

Care managers, providers, or Medicaid beneficiaries can call their county LME-MCO directly with TP questions related to topics including PCP selection or changes, and value-added services:

- **Alliance Health Member Support Line:**
  1-800-510-9132
  Monday – Saturday, including holidays 7 a.m. – 6 p.m.
- **Vaya Health Member Support Line:**
  1-800-962-9003
  Monday – Saturday 7 a.m. – 6 p.m.

Opting Out of Tailored Plan Coverage

Some Medicaid recipients will be automatically enrolled in a Tailored Plan based on their needs. There are often benefits to accessing the enhanced set of behavioral services provided in the Tailored Plan, but some individuals may prefer the coverage of a Standard Plan. To opt out of Tailored Plan coverage, Medicaid recipients can contact the Medicaid enrollment broker by calling 1-833-870-5500, 7 a.m. – 5 p.m. Monday – Saturday; TTY: 711; or online or RelayNC.com.