

NC Medicaid Managed Care: What Advocates Need to Know

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AGENDA

- NC Medicaid Managed Care Structure
- Who must Enroll/Enrollment Process
- Beneficiary Protections and Rights
- Issues to Watch
- Other Resources
- Q and A

NC Medicaid Managed Care Structure

Background: Existing NC Medicaid Program

- Medicaid is an entitlement program that provides health insurance to some low-income populations.
- In November 2018, there were more than 2 million people covered by Medicaid in NC (out of ~10.3 million)
 - There were an additional ~100,000 children covered by NC Health Choice
- Currently, Medicaid operates through fee-for-service (FFS, state paying providers)
 - Community Care of North Carolina helps coordinate care for physical health services
 - Exceptions: Local Management Entities/Managed Care Organizations (LME/MCOs and PACE)



Existing Managed Care in North Carolina

- While most of Medicaid operates under a fee-for-service system, services for mental health, developmental disabilities, and substance use disorder are provided through managed care.
- Local Management Entity/Managed Care Organizations (LME/MCOs):
 - Contract with the NC Department of Health and Human Services (NC DHHS) to manage these services, e.g., Innovation waiver, “B3” services.
 - Capitated payments and closed network of providers.
- 7 regional LME/MCOs operating in N.C.:
 - Alliance Health
 - Cardinal Innovations Healthcare
 - Eastpointe
 - Partners Behavioral Health Management
 - Sandhills Center
 - Vaya Health
 - Trillium Health Resources

On July 1, 2021, N.C. Medicaid is Transitioning from Fee-for-Service to Managed Care for Other Services

- Most N.C. Medicaid and CHIP beneficiaries will be required to enroll in one of five capitated managed care Prepaid Health Plans (PHPs).
- Some populations excluded (can't enroll initially) or exempt (have the choice of whether to enroll now or wait).
- PHPs will approve or deny requests for prior authorization of some services.

Design for the New Managed Care Delivery System

Each Plan will have provider network. Services generally will have to be obtained from in-network providers.

Focus on health outcomes and care management.

“Standard Plans” for most Medicaid beneficiaries. Coverage starting July 1, 2021.

“Tailored Plans” for those with severe MI or DD (scheduled to start in July 2022). Eligible based on diagnosis or use of services.

See, e.g., <https://files.nc.gov/ncdma/NCMedicaid-Provider-FactSheet-Medicaid-Transformation-Overview-20190925.pdf>

What is NOT Changing?

- Eligibility rules and application process for Medicaid and HealthChoice (CHIP)
- Covered services
 - Some services have been added by plans
- How services are authorized and delivered for EXEMPT populations
- Clinical coverage policies (for now)
- Waiver waitlists

Individuals Get a Choice of Plans

- 60 days (until May 15) to selection a health plan (PHP) and primary care provider (PCP)
 - Those who do not select a health plan will be auto-assigned to one based on certain criteria
 - Members who do not select a PCP will be auto-assigned by the PHP to a provider.
 - Member can change PCP at least twice per year
- Plan members will have 90 days after plan coverage begins to change their PHP for any reason (whether that person chose a plan or was auto-assigned)
 - Members can change PHPs only for good cause after the 90-day period until the next year (Right to appeal if good cause denied).
- Those who are exempt but choose to enroll can disenroll at any time

Standard Plans

- **Blue Cross Blue Shield** - statewide
- **AmeriHealth Caritas** - statewide
- **United Health Care** - statewide
- **WellCare** - statewide
- **Carolina Complete Health, Inc.** – Regions 3, 4, and 5
 - Provider-led entity partnership between NC Medical Society (NCMS) and Centene Corporation, working with the NC Community Health Center Association (NCCHCA)
- **Eastern Band of Cherokee Indians (EBCI) Tribal Option**
 - Managed by the Cherokee Indian Hospital Authority
 - Only available to Medicaid beneficiaries eligible for Indian Health Services (IHS)
 - Primarily in Cherokee, Graham, Haywood, Jackson, and Swain counties
 - Eligible beneficiaries in Buncombe, Clay, Henderson, Macon, Madison, and Transylvania counties may opt in

Health Plan Choice Guide

(p.1), available as part of the [County Playbook](#)

SAMPLE



Health Plan Choice Guide

All health plans are required to have the same type of Medicaid services you get now. These include:

- Doctor visits
- Hospital visits
- Behavioral health care
- Prescriptions
- Eye care
- Medical supplies
- Lab tests and X-rays
- Therapies
- Hospice
- Care management

To see the full list of NC Medicaid covered services provided by the health plans, go to ncmedicaidplans.gov. Health plans also have added services. To view added services, see the other side.

<p>1-800-260-9992 TTY: 711 EBCITribalOption.com</p> <p>8 a.m. to 4:30 p.m., Monday through Friday</p>  <p>Only available in the counties listed below</p>	<p>1-866-799-5318 TTY: 711 www.wellcare.com/nc</p> <p>7 a.m. to 6 p.m., Monday through Saturday</p>  <p>Statewide (all 100 counties)</p>	<p>1-800-349-1855 TTY: 711 uhcommunityplan.com/nc</p> <p>7 a.m. to 6 p.m., Monday through Saturday</p>  <p>Statewide (all 100 counties)</p>	<p>1-844-594-5070 TTY: 711 healthybluenc.com</p> <p>7 a.m. to 6 p.m., Monday through Saturday</p>  <p>Statewide (all 100 counties)</p>	<p>1-855-375-8811 TTY: 1-866-209-6421 amerihealthcaritasnc.com</p> <p>24 hours a day, 7 days a week</p>  <p>Statewide (all 100 counties)</p>	<p>1-833-552-3876 TTY: 711 carolinacompletehealth.com</p> <p>7 a.m. to 6 p.m., Monday through Saturday</p>  <p>Only available in the counties listed below</p>

EBCI Tribal Option is only available in Cherokee, Graham, Haywood, Jackson and Swain counties. Eligible members in the following counties may opt in: Buncombe, Clay, Henderson, Macon, Madison, and Transylvania

Carolina Complete Health is only available in these counties: Alamance, Alexander, Anson, Bladen, Brunswick, Cabarrus, Caswell, Catawba, Chatham, Cleveland, Columbus, Cumberland, Durham, Franklin, Gaston, Granville, Harnett, Hoke, Iredell, Johnston, Lee, Lincoln, Mecklenburg, Montgomery, Moore, Nash, New Hanover, Orange, Pender, Person, Richmond, Robeson, Rowan, Sampson, Scotland, Stanly, Union, Vance, Wake, Warren, Wilson

Questions? Go to ncmedicaidplans.gov. Or call us at **1-833-870-5500** (TTY: 1-833-870-5588). The call is free. We can speak with you in other languages. You can get this information in other languages or formats, such as large print or audio.

Health Plan Choice Guide (p.1), available as part of the [County Playbook](#)

Use this guide to view **added services** each health plan offers. **Some services may only be available for members who qualify.** For questions, call **1-833-870-5500** (TTY: 1-833-870-5558).

 EBCI TRIBAL OPTION	 WellCare Beyond Healthcare. A Better You.	 UnitedHealthcare Community Plan	 HealthyBlue	 AmeriHealth Caritas North Carolina	 carolina complete health
<p>Education</p> <ul style="list-style-type: none"> Up to \$250 General Educational Development (GED) exam voucher, materials and life skills training Up to \$750 voucher for Associate Degree tuition and materials Up to \$250 voucher for a computer if accepted and enrolled full time in an institution of higher education <p>Prenatal</p> <ul style="list-style-type: none"> Up to \$75 in gift cards if go to prenatal appointments <p>Wellness</p> <ul style="list-style-type: none"> Offers of nutrition, cooking, and exercise classes <p>Youth</p> <ul style="list-style-type: none"> 1 pair sport shoes per calendar year Car safety seat with installation and use education <p>Other</p> <ul style="list-style-type: none"> Cherokee Language classes and supplemental learning materials Transportation for job training and other activities to implement person's care plan 	<p>Education</p> <ul style="list-style-type: none"> \$120 GED voucher, including GED testing, tutoring, and reading scholarships <p>Prenatal</p> <ul style="list-style-type: none"> Up to \$450 in rewards for baby products; stroller, playpen, car seat, or diapers <p>Wellness</p> <ul style="list-style-type: none"> \$75/year rewards gift cards 20% CVS discount card 24-week voucher for Weight Watchers® <p>Youth</p> <ul style="list-style-type: none"> Boy Scouts, Girl Scouts and 4-H Club membership <p>Other</p> <ul style="list-style-type: none"> Hearing aid (up to \$300) Up to \$120 yearly for over-the-counter drugs Cell phone with 350 monthly minutes, free texts, 3 GB data Rides to covered services for Health Choice members and rides to classes and events for all members 	<p>Education</p> <ul style="list-style-type: none"> Up to \$160 GED exam voucher, materials, and life skills training <p>Prenatal</p> <ul style="list-style-type: none"> Free electronic breast pump Up to \$100 in rewards for baby products <p>Wellness</p> <ul style="list-style-type: none"> \$75/year rewards gift cards 13-week voucher for Weight Watchers® <p>Youth</p> <ul style="list-style-type: none"> \$75 yearly for membership at Boys and Girls Club or YMCA <p>Other</p> <ul style="list-style-type: none"> \$100 yearly value in alternative healing, acupuncture, massage therapy Up to \$150 for hypoallergenic mattress cover and pillowcase for asthma Cell phone with 350 monthly minutes, free texts Free meal delivery up to 14 days after hospital stay, if qualify 	<p>Education</p> <ul style="list-style-type: none"> \$50 annual gift card for school supplies GED exam voucher (up to \$160 value) 24 hours of online tutoring for eligible members ages 6-18, if qualify <p>Wellness</p> <ul style="list-style-type: none"> Up to \$75 yearly rewards for doctor visits 13-week voucher for WW® (formerly Weight Watchers) 3 months of fresh fruits and veggies for qualifying members <p>Youth</p> <ul style="list-style-type: none"> \$75 yearly for membership like Boys and Girls Club, Boy Scouts, or Girl Scouts Up to \$150 for after school activities <p>Other</p> <ul style="list-style-type: none"> Cell phone with monthly data, minutes and bonus minutes \$20 Uber gift card for college students for grocery stores, local events 	<p>Education</p> <ul style="list-style-type: none"> GED program with free practice and regular tests <p>Prenatal</p> <ul style="list-style-type: none"> High-risk pregnancy home educational visits <p>Wellness</p> <ul style="list-style-type: none"> \$75/year rewards gift cards Weight Watchers® membership for qualifying members <p>Youth</p> <ul style="list-style-type: none"> Boys & Girls Club membership, ages 18 and younger Home visits, supplies for children with asthma, ages 2-18 <p>Other</p> <ul style="list-style-type: none"> Pain management education and support Extra pair of glasses and eye exam every 2 years, ages 21-64 2 meals per day for up to 7 days after hospital stay Smart phone with 1,000 minutes, unlimited texts, & 1 GB data per month 	<p>Education</p> <ul style="list-style-type: none"> GED exam voucher, study materials \$75/year value school supplies, online tutoring, members grades PreK-12 before GED <p>Prenatal</p> <ul style="list-style-type: none"> Up to \$100 per year for new mothers; car seat, diapers, diaper bag, breast pump, high-risk pregnancy visits <p>Wellness</p> <ul style="list-style-type: none"> \$75 per year rewards card \$120 per year for approved healthy foods at Walmart® Up to 14 weeks of Weight Watchers® and online tools <p>Youth</p> <ul style="list-style-type: none"> \$75 per year value after school sports/activities/youth club membership, ages 6-18 <p>Other</p> <ul style="list-style-type: none"> \$125/year for glasses, contacts for members ages 21 & up \$120/year per household for over-the-counter products Cell phone with 250 monthly minutes, free calls, texts

Covered Services

Non-Emergency Medical Transportation (NEMT) will be PHP's responsibility. County DSS still responsible for excluded population.

PHPs offering "in lieu of" or "value-added" services after approval by NC DHHS.

Cost sharing will remain the same (\$1-\$3 for Medicaid, \$1-\$25 for NC Health Choice (CHIP or NCHC)).

Certain services carved out (remains in FFS), including dental services, eyeglasses, Local education agency (LEA) services, Children's Developmental Services Agency services.

Right to Non-Emergency Medical Transportation (NEMT)

- Plans will be required to provide NEMT services for enrolled individuals.
 - Individuals will receive the same service from Plans as they received under N.C. Medicaid Direct
 - The amount, duration, and scope of NEMT service will NOT change
 - High utilizers of NEMT will be identified (in coordination with local DSSs) and Plans are supposed to reach out to them
- Individuals should contact their plan's NEMT contact to schedule NEMT
 - N.C. Medicaid Managed Care members can contact their Plan starting June 1, 2021 for trips taking place on or after July 1, 2021.

Right to NEMT (Cont.)

- Members will:
 - Be informed: there is no cost for NEMT services, of who may accompany them without cost, and that any member under 18 must have an adult present
 - Have the Plan NEMT policy explained (e.g., how to request or cancel a trip, limitations on transportation, advanced notice requirements, expected member conduct and procedures for no-shows)
 - Be able to arrive at provider's location in time for scheduled appointment
 - Not have to wait more than 1 hour after conclusion of treatment for transportation home
 - Not be picked up prior to completion of treatment
 - Be able to request an appeal if request for transportation assistance is denied

Plan Requirements for NEMT

- Plans must:
 - Provide NEMT appropriate for the member to the nearest enrolled medical provider
 - Provide NEMT to a Medicaid-covered service provider, including services not covered through N.C. Medicaid Managed Care, provided by a qualified Medicaid provider
 - Provide travel-related expenses including:
 - Lodging, food, parking fees/tolls, transportation vouchers
 - Develop a network of NEMT providers
- Plans are also required to:
 - Provide training to NEMT providers
 - Address behavioral issues during transportation
 - Establish reimbursement rates
 - Have contractual requirements for quality of care, vehicles, drivers, timeliness, and no-shows

What Happens to LME/MCOs?

- **Until July 2022:**
 - LMEs continue managing care for MH/DD/SA but only for those with severe conditions (next slide).
 - Physical health care for this population continues to be Fee for Service (Medicaid Direct).
- **Beginning July 2022, LMEs become Tailored Plans:**
 - Tailored plans will manage both MH/DD/SA services and physical health care BUT only for those with severe conditions.
 - Only one tailored plan per region
 - **no beneficiary choice of plans at beginning, at least**
 - Only LME-MCOs can apply to be tailored plans
 - Contract runs through July 2026

Behavioral Health Services

Standard Plans	Tailored Plans/LMEs before July 2022
<ul style="list-style-type: none"> • Inpatient behavioral health services • Facility-based crisis services for children and adolescents • Nonhospital medical detox services • Partial hospitalization • Diagnostic assessment services • Mobile crisis management services • Professional treatment services in a facility based crisis program • Medically supervised or ADATC detox crisis stabilization • Outpatient behavioral health emergency room services • Outpatient opioid treatment services • Research-based intensive behavioral health treatment • Outpatient behavioral health services provided by direct-enrolled providers • Ambulatory detoxification services • DRAFT: Research-based Intensive Behavioral Health Treatment for Autism Spectrum Disorder 	<ul style="list-style-type: none"> • All the same as Standard plan plus enhanced services: • Residential treatment facility services • Child and adolescent day treatment services • Intensive in-home services • Multi-systemic therapy services • Psychiatric residential treatment facilities (PRTFs) • Assertive community treatment (ACT) • Community support team (CST) • Substance use disorder non-medical community residential treatment • Substance use disorder medically monitored residential treatment • ICF/IDD • Waiver services (TBI, innovation, 1915(b)(3)) • State-funded BH/IDD/TBI services

Care Management Requirements

- More Medicaid enrollees will have access to care management to address medical and nonmedical drivers of health care.
- Local care management to be provided by Tier 3 advanced medical homes (AMHs) and Local Health Departments (LDHs).
- PHPs will have to identify high-needs members needing care management and provide care management to help them access nonmedical drivers of health, including:
 - Housing,
 - Food,
 - Transportation, and
 - Interpersonal safety.
- Must provide transitional care management for those moving from one clinical setting to another. PHP will have to employ housing specialist, assist with SNAP applications, refer to medical-legal partnerships.
- Local care management preferred (in site of care, home, or community that is face-to-face).

Healthy Opportunities Pilots

- Healthy Opportunities Pilots will provide evidence-based, non-medical interventions for high-needs individuals on Medicaid.
- Aim to improve health outcomes and reduce healthcare costs for individuals covered by Medicaid.
- Focus on housing, food, transportation, and interpersonal safety.
- Embedded into Medicaid Managed Care
 - E.g., PHPs manage the Pilot budget, approve member eligibility for Pilot services, and pay Human Service Organizations (HSOs) for services delivered.
- Lead Pilot Entities (LPEs) will be selected to develop and oversee network of Human Service Organizations
 - Pilots will operate in 2-4 geographic regions
- Awards expected to be announced Spring 2021, with pilot service delivery beginning early 2022.

Who Must Enroll and the Enrollment Process

The Enrollment Process So Far

- Letters/enrollment packets were mailed to beneficiaries in early March.
- Enrollment website went live March 1.
- Live chat feature on Enrollment website, manned by people, not an automated process.
- Some individuals who are exempt have enrolled in Plans.
 - Plans are supposed to reach out to these individuals to make sure they can continue getting services they need.

Open Enrollment began Monday, March 15!

- Other relevant dates:
 - Auto enrollment: May 15th
 - Managed care and tribal option launch: July 1st
 - End of choice period: September 21st

Enrollment Broker's Duties

- Help beneficiaries understand managed care, who must enroll, who may enroll, who can't enroll.
- Assist with enrollment process.
- Communicate with individuals in their preferred method, e.g., email, phone, text, mobile app.
- Conduct outreach and proactive engagement to facilitate enrollment.
- Provide unbiased, culturally competent choice counseling
- Provide accurate information to help consumers compare plans and provider networks to allow intelligent choice of health plans.
- Assist in disenrolling/changing plans if needed.

ncmedicaidplans.gov
Call Center opened March 1, 2021

Avenues for Enrollment in Managed Care Health Plans

- **NC Medicaid Managed Care mobile app:**
 - Available on iOS and Android
- **Enrollment Broker Call Center (Maximus):**
 - Phone: 1-833-870-5500
 - TTY: 1-833-870-5588
 - During Enrollment:
 - 7 a.m.–8 p.m.
 - 7 days/week
 - All other times:
 - 7 a.m.–5 p.m. Mon.–Sat.
- **Mail:**
 - NC Medicaid, PO Box 613, Morrisville NC 27560
- **Fax:** 1-833-898-9655
- **In-Person:**
 - Enrollment Broker Staff may be located at county DSS' and outreach sites depending on COVID developments

Who Must Enroll?

Who is Exempt or Excluded?

IN:

- “Mandatory” Must Enroll: All Medicaid and CHIP participants UNLESS Exempt or Excluded - includes most Family & Children’s Medicaid, NC Health Choice, Pregnant Women Non-Medicare Aged, Blind, Disabled (including beneficiaries residing in Adult Care Homes)

“Exempt” Permitted to Enroll:

- Federally recognized tribal members or others eligible for Indian Health Services (IHS)
- Beneficiaries with serious ID/DD or Mental Illness (until Tailored Plans begin)

OUT: “Excluded” (*means Delayed)

- | | |
|---|---|
| <ul style="list-style-type: none">• Medically Needy• Presumptive eligibility• Emergency Medicaid• HIPP program• Family planning• Individuals in prison• Medicare-Aid (MQB, QI-1)• PACE• Refugee Medicaid• COVID-19 Program | <ul style="list-style-type: none">• CAP/C*• CAP/DA*• Innovations Waiver*• TBI Waiver*• Nursing facility residents (90 days or more)*• Dual eligible (Medicare)*• Foster Care/Adoption Medicaid* |
|---|---|



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**
Division of Health Benefits

Questions? Go to ncmedicaidplans.gov. Or call us at **1-833-870-5500** (TTY: 1-833-870-5588). The call is free. We can speak with you in other languages.

ENROLLMENT PACKET NOTICE TO HOUSEHOLD WHERE ALL PEOPLE MUST CHOOSE A HEALTH PLAN (MANDATORY)
NC Medicaid 20210106 v1.0

Patricia A. Jones
1234 Any Main Street
Raleigh, NC 27603-1000

March 1, 2021

Dear Patricia A. Jones:

There will be a new way to get Medicaid health care

Starting July 1, 2021, most people will get the same Medicaid services in a new way – through health plans.

A **health plan** is a group of doctors, hospitals and other providers. They work together to give you the health care you need. Everything will come from the same health plan. This includes – physical health, behavioral health and medicine. Some health plans provide added services like programs to help you quit smoking.

NC Medicaid Direct is North Carolina's current health care program for Medicaid members. It will continue to provide the same services including developmental disability, behavioral health, traumatic brain injury and substance use disorder services for members who need these special services.

Even if you previously chose a health plan, you will need to choose again. If you don't choose a health plan, we will choose one for you. You know your needs best, so it's better if you choose.

Some things will stay the same

Medicaid eligibility rules and processes are not changing.

More on back ►

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To get this information in other languages or formats such as large print or audio, call **1-833-870-5500**.

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Sample MANDATORY Enrollment Letter

Other Sample Letters found in the [County Playbook](#) under Beneficiary Notices

Beneficiaries Sent Mandatory Letters Who may be exempt

- State relied on data matches to determine who must enroll, who is Exempt, who is Excluded.
- State had no historical data on those new to Medicaid or new to NC.
- State had limited data on other groups (e.g., those ages 0-3, those involved with juvenile justice system).

Two Different Paths to Stay in Medicaid Direct

Diagnosis

Includes individuals with:

- serious emotional disturbance, or diagnosis of severe substance use disorder, or TBI; or
- developmental disabilities, as defined in GS 122C-3(12a); or
- serious MH, as defined by the 2012 settlement agreement with DOJ, including those in the Community Living Initiative settlement
- Children involved with juvenile justice system or Children with Complex Needs (CWCN; dual diagnosis)

February 2021 Updates:

[Criteria for Tailored Plan Exemption from Mandatory Enrollment in NC Medicaid Standard Plans](#)
[Tailored Plan Memo on Eligibility and Enrollment Updates](#)

OR Use of Services

Includes individuals:

- with 2 or more psychiatric hospitalizations or readmissions within prior 18 months; or
- with 2 or more visits to the ED for psychiatric problems in the past 18 months; or
- who have been involuntarily treated within prior 18 months

Request to Stay in NC Medicaid Direct

- Allows Beneficiaries to Self-Identify as Exempt or Excluded.
 - Beneficiaries incorrectly identified by data match as mandatory or whose circumstances change can request in writing that they be disenrolled (transferred from standard plan to FFS/LME) by filling out a [form found here](#).
- Care coordinators or care managers may assist beneficiaries in completing form.
- Provider can also request disenrollment/transfer on a different [form found here](#).
- DHHS decision on request mailed to beneficiary, and decision can be appealed to Office of Administrative Hearings (OAH) within 30 days.
- The forms can also be submitted online [here](#).

What Should Medicaid Beneficiaries Do Now?

Ensure address and contact information is up to date with local DSS

Ask providers and specialists what PHPs they've contracted with

Look out for mail notifying them about the changes

Call Enrollment Broker to find out if they must enroll in a Standard Plan and discuss the best choice for them

Appeal if request to stay in NC Medicaid Direct is denied

Request NEMT from their PHP starting June 1 for transportation July 1 or after

Beneficiary Rights and Protections

NC Medicaid Ombudsman

- Legal Aid of North Carolina, in partnership with the Charlotte Center for Legal Advocacy and Pisgah Legal Services will provide Medicaid Managed Care Ombudsman services for the state's Medicaid beneficiaries **beginning April 15, 2021.**
- Contact the Ombudsman:
 - By phone (starting April 15): **877-201-3750** Toll Free
 - M-F, 8am-5pm
 - Online: **ncmedicaidombudsman.org**

NC Medicaid Ombudsman

- **Services Provided:**
 - **Information and Education:** to inform beneficiaries of their rights and to help answer questions over the phone, website, email, by mail and in person
 - **Issue Resolution and Management:** as the central resource to resolve issues within the Medicaid Managed Care delivery system
 - **Referrals:** to support beneficiaries' access to care in collaboration with other resources including State agencies, Department partners, community-based advocacy and legal service organizations
 - **Trend Monitoring:** to identify trends or systemic issues in delivery system performance

Beneficiary Protections



Department must approve all marketing materials, PHPs cannot engage in direct solicitations.



PHPs must provide language assistance services, must establish a member advisory committee, LTSS member advisory committee, and must facilitate transfers to different plans, or different providers, when appropriate.



PHP must operate member services line, behavioral health crisis lines, and a nurse line.



Grievance, appeal, and state fair hearing procedures, including timeliness standards

Transition of Care Protections Include:

- Plan and LMEs must transfer information necessary to ensure continuity of care.
- Plans must honor existing and active fee-for-service prior authorizations for 90 days after Managed Care goes live, or until end of authorization period if sooner.
 - If PHP terminates or reduces open authorization at 90 days, it must issue appeal rights.
- Assist transitioning to in-network provider at end of authorization period if necessary.
- Allow continuation of Ongoing Course of Treatment with current provider in accordance with law – may extend beyond 90 days (N.C. Gen. Stat. 58-67-88(d)-(g)).
- Pregnant members may continue receiving services from BH treatment provider without prior authorization until birth, end of pregnancy or loss of eligibility.

Transition of Care Protections Include:

- Plans must pay claims and authorize services for Medicaid eligible nonparticipating/out-of-network providers equal to that of in-network providers for the first 60 days after Managed Care launch.
- PHP bears financial responsibility of certain claims of members admitted to inpatient facility while covered by Plan through discharge.
- For beneficiaries authorized for services under the Unmanaged Visits for Outpatient Behavioral Health Services Clinical Coverage Policy when Managed Care goes live, their unmanaged visit count resets to zero.
- For high-need individuals, LMEs must give PHPs a verbal briefing and PHPs must provide expedited follow up after launch, and provide additional assessments needed to evaluate continuation of services.

Network Adequacy

- PHPs must meet DHHS' network adequacy standards (time/distance, and appt. wait times).
 - Must maintain provider directory (updated at least monthly) that includes provider name, geographic location, provider specialty, provider linguistic capabilities, whether provider's accepting new Members, office accessibility
 - Cannot exclude providers from the network, unless the provider fails to meet quality standards or fails to accept network rates
 - May use telemedicine to help increase access, but cannot require individuals to use telemedicine
- Must contract with all essential providers located in PHP's region, unless alternative arrangements approved by DHHS.
- DHHS will establish a standardized, centralized provider credentialing process.

Plans Must Cover Out-of-Network Care for:

- Emergencies and urgent care
- Family planning services
- Care needed while traveling out of state
- Service not available in-network in a timely manner.
- During Transition of Care period

When a PCP Referral is Not Required:

- All situations on the last slide
- Children's screening
- School based services
- Health Dept services
- Women's health services
- Behavioral Health or Substance Abuse Assessment

Beneficiary Rights Under Managed Care

- **Get free advice** over the phone from Enrollment Broker (Maximus) about whether they are exempt and, if not, which plan is the best choice.
- **Switch plans** for any reason within 90 days of coverage beginning, or for “good cause” at any time during the year.
- **Request to disenroll from a plan or from managed care** from the enrollment broker and appeal if denied.
- **Get out of network care** if medically necessary services are not available promptly in the health plan’s network.
- **No interruption of care** when transitioning between plans or out of managed care.
- **Appeal** if the health plan denies, reduces, or stops coverage for needed health care.

Source: <https://files.nc.gov/ncdma/documents/Clinical-Policies-Webinar-FINAL20190613.pdf>

Issues That May be Appealed

- Denied authorization for requested services;
- Denial of out-of-network services when care not available in health plan's network;
- Reduction or termination of authorized services;
- Decision on disenrollment.

Notice of Adverse Action

- Health plan must issue written notice of adverse decision on decision to deny, stop, or reduce coverage of services.
- Notice must include specific reason for decision and supporting criteria.
- Notice must explain when and how to appeal and include appeal form and instructions.
- Notice must include how to request continuation of services pending appeal if services stopped or reduced during authorization period.

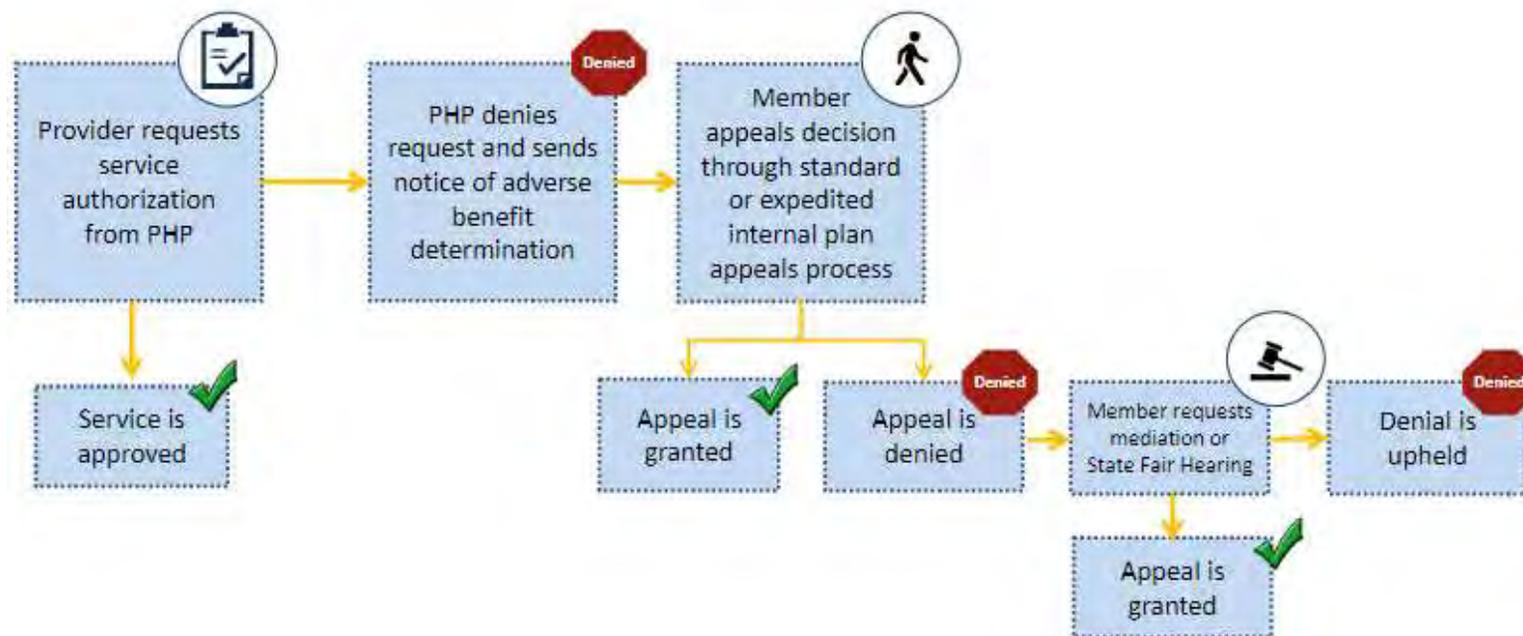
Appeal Process-Step One: Reconsideration by Plan

- First level of appeal is reconsideration by PHP.
- Deadline to appeal is 60 days from date of notice.
- Appeal can be filed orally or in writing.
- Can request that appeal be expedited if imminent threat to health.
- Right to copy of plan file and to offer new information.
- Right to be represented by attorney or anyone else.
- Decision by Plan required within 30 days.
- Decision must be in writing with appeal rights.

Appeal Process Step Two: Appeal to N.C. OAH

- Must appeal within 120 days of plan decision.
- Can request appeal orally or in writing.
- After requesting appeal, option to attend informal mediation with PHP to try to resolve the dispute.
- If mediation fails (or is declined) formal hearing scheduled with Administrative Law Judge (ALJ) at NC Office of Administrative Hearings (OAH).
- Right to free copy of Plan file.
- Right to be represented by attorney or anyone else.
- Adverse ALJ decision can be appealed to court.

Appeals Process



Source: <https://files.nc.gov/ncdma/documents/Clinical-Policies-Webinar-FINAL20190613.pdf>

Disenrollment Appeals

- Only 30 days to file appeal from date of decision.
- Appeal is directly to OAH.
- See N.C. Gen. Stat. 108D-5.9

Issues to Watch

Provider Networks Are Not Yet Complete

- Many providers have been slow to enroll in plan networks.
 - Hearing concerns particularly from providers who work for hospital systems.
- Concerns around provider search tools being up to date and problems finding providers with it.
- Beneficiaries may wish to wait to enroll until provider information is more complete or change plans during the 90 day grace period after coverage begins if needed.

Enrollment Issues

- Notices to exempt beneficiaries confusing as to whether to enroll in PHP.
- Some Spanish speakers getting notices in English.
- Will Enrollment Broker be able to handle increased demand from no staggered rollout?
- Will county DSSs and DHHS promptly look for new addresses and resend enrollment notices returned undelivered?
- Exempt beneficiaries:
 - Told by Enrollment Broker to enroll anyway?
 - Informed of right to disenroll at any time?

Enrollment Issues

- Is enrollment broker easily accessible and helpful to beneficiary in choosing a plan? In requesting to stay in Medicaid Direct or to change plan?
- Is enrollment broker providing current, accurate, unbiased information?
- Will beneficiaries with good cause be able to change plans after 90 days? Will plan and EB tell them this?
- Will a request to change plans be acted on properly/promptly by EB and plans?
- Will auto assignment algorithm assign beneficiaries to best plan for them?

Disenrollment Issues

- If beneficiary w/severe MI/DD files request to disenroll from managed care, is decision promptly issued in writing with appeal rights if request denied?
- If mental health condition worsens so that need for enhanced MH services, will beneficiary be smoothly transitioned from PHP to LME without interruption in care or delay in getting needed services? Will these patients bounce back and forth between PHPs and LMEs?
- If beneficiary begins receiving Medicare or starts getting CAP-DA or CAP-C services, will she be promptly disenrolled from managed care?
- Will plans seek to disenroll high cost or “difficult” members?

Stakeholder Involvement

- Managed care design requires member advisory committees
- How will plans recruit membership?
- Will the committees represent the enrolled population?
- How will the plans support meaningful participation and impact from these committees?

Access to Info/Assistance

- Do plan member handbook and other beneficiary materials accurately describe client benefits, rights and procedures, including appeal process?
- Do all materials for beneficiaries say how to contact ombudsman? How to contact legal aid?
- Is beneficiary's care manager easily accessible by phone? Respond promptly?
- Do plan, providers and enrollment broker meet Section 1557 requirements for persons with Limited English Proficiency (LEP) or a disability (e.g., translator, written materials, assistance meeting requirements)?
- Do plan, providers and enrollment broker provide services in culturally competent way (including to persons with different sexual orientation)?

Access to Care Issues

- Is plan's provider directory accurate? Are the providers listed actually accepting new Medicaid patients?
- Is beneficiary allowed to change primary care physician (PCP) without cause twice per year?
- Does beneficiary need an Advanced Medical Home? If so, will plan provide one?
- Will plan assure that PCP provides quality care management to beneficiary?
- Will beneficiaries have timely access to appointments and start of treatment at nearby appropriate providers for all services needed, including specialty care, in home care, mental health treatment?

Access to Care Issues

- Will plans tell beneficiary when a right to out of network care?
- Will beneficiaries be denied out of network provider where plan cannot provide timely access to the same service through in network provider?
- Will plans tell client of right to free transportation to medical appointments if needed?
- If transportation is requested and denied, will denial be in writing with appeal rights?

Access to Care Issues

- Will plan cover all services required under state plan plus any service that can be covered under EPSDT?
- Will plans meet mental health parity requirements in coverage policies, disclosure requirements, and decisions?
- Will plans follow state definition of medical necessity?
- Will plans comply with EPSDT requirements for outreach, informing, screening, coverage decisions, and arranging for service for those under age 21?
- Will plans limit period of authorization of long-term services and supports to unreasonably short period of time, requiring reauthorization less than annually for chronic conditions?

Denial of Care Issues

- Will plans discourage requests for services or give misinformation about coverage?
- Will plans make decisions on requests for services in a timely manner?
- Will plans comply with state clinical policies in making coverage decisions, instead of internal, unpublished criteria or algorithm?

Denial of Care Issues: Notices

- Will plans provide written notice whenever care denied, partially approved, reduced or stopped (unless at end of authorization period and reauthorization was not requested)?
- Is the written notice on the state's approved form?
- Are all required enclosures enclosed with the notice? Are the enclosures pre-populated with all relevant info about this decision?
- Is the written notice on the correct form for the type of decision made?
- Does written notice specify reason for decision and legal authority?
- Does written notice say how much of each service approved/denied?
- Does written notice provide right to continued services pending appeal if termination or reduction before end of current authorization period?
- Is envelope postmarked the same day as date on the notice?

Appeal Process Issues

- If appeal requested, will it be timely processed by the plan?
- If beneficiary needs expedited appeal, will PHP act quickly?
- Will plan offer assistance in filing appeal or during appeal process?
- Will plan discourage appeal or continuing the appeal?
- Will plan allow appeals to be filed over the phone?
- Will plan provide access to entire file free of charge?
- Will plan allow beneficiary to present case in person?
- Will appeal be decided by independent person with appropriate credentials?

Appeal Process Issues

- Will plan's appeal decisions be timely?
- Will plan appeal decisions be on the correct state form?
- Are all required enclosures included with that decision? Are they prepopulated?
- Will plan make entire beneficiary file available free of charge during OAH appeal?
- Will OAH expedite the appeal if warranted and requested?
- Will PHP continue services pending OAH appeal if required?

Other Resources

DHHS Issue Resolution

- **Providers:**
 - **NCTracks Call Center:** 800-688-6696
 - For provider enrollment in Medicaid or NC Health Choice, Prior Authorizations before July 1, Recipient eligibility, claims, processing, billing questions before July and continuing after July 1 for NC Medicaid Direct
 - **NC Medicaid Help Center:** supplemental resource for providers (not beneficiaries) to provide information about Managed Care, COVID-19, and Medicaid and behavioral health services.
 - Provides answers to questions from NC Medicaid Help Center mailbox, webinars, and other sources
 - https://ncgov.servicenowservices.com/sp_ncmedicaid?id=kb_view_helpcenter
 - **Provider Ombudsman:** 919-527-6666
 - Medicaid.ProviderOmbudsman@dhhs.nc.gov
- **Beneficiaries:** NC Medicaid: 833-870-5500
- **NC Medicaid Contact Center:** 888-245-0179
 - Provider and beneficiary information on Medicaid and NC Health Choice policies and procedures

More NC DHHS Information

- **NC DHHS Medicaid Transformation Homepage:** <https://medicaid.ncdhhs.gov/transformation>
- **Provider Playbook:** <https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care>
- **County Playbook:** <https://medicaid.ncdhhs.gov/counties/county-playbook-medicaid-managed-care>
- **Provider trainings:** <https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/provider-playbook-training-courses>
- **NC Medicaid Transformation Policy Papers:** <https://www.ncdhhs.gov/assistance/medicaid-transformation/proposed-program-design/policy-papers>
- **Advanced Medical Home Information:** <https://medicaid.ncdhhs.gov/transformation/advanced-medical-home>
- **Medicaid managed care Requests for Proposals (for PHPs) and Related Resources:** <https://www.ncdhhs.gov/request-information>

WHAT CAN YOU DO?



Spread the word!

Medicaid transformation is coming!
Help clients understand their options!

Make your voice heard! Call your state legislators and tell them to support expanding Medicaid and closing the coverage gap!

The new COVID relief bill offers an additional \$2.4 billion in incentives over two years for North Carolina to expand Medicaid.

Questions? Seeing Problems?



NCMedicaidIssues@gmail.com

Medicaid Transformation system and process concerns

*Monitored by advocates to gain information

***NOT** an official reporting mechanism to the State or any other entity ⁶⁸