N.C. Medicaid Managed Care: What's Going On?

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September 30, 2019

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justice lives here.

Agenda

- What's Supposed to Happen
- What's Happened So Far
- What to Watch For
- Resources for Beneficiaries and Advocates
- Q&A

What's Supposed to Happen

What's Supposed to Happen

Background: Existing NC Medicaid Program

- Medicaid is an entitlement program that provides health insurance coverage to some low-income populations.
- In Nov. 2018, there were more than 2 million people covered by Medicaid in North Carolina (out of ~10.3 million)
  - There were an additional ~100,000 children covered by NC Health Choice
- Currently, Medicaid operates through fee-for-service (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

What's Supposed to Happen

New Delivery System: Managed Care

- Most N.C. Medicaid and CHIP beneficiaries must enroll in one of five capitated managed care Prepaid Health Plans (PHPs).
- Some populations excluded or exempt.
- PHP will approve or deny requests for authorization of services.
- Services generally must be obtained from in-network providers.
- Focus on health outcomes and care management.
- Standard Plans for Most Beneficiaries.
- Tailored Plans for those with severe MI or DD (starting in 2021).

What's Supposed to Happen

What is NOT Changing Under Medicaid Transformation?

- Eligibility rules and application process for Medicaid and Health Choice (CHIP).
- Covered Services (except some new services being added).
- How services are authorized/delivered for exempt populations.
- Waiver waitlists.
- Clinical coverage policies (for now).

Who Must Enroll?
Who is Exempt or Excluded?

IN:

- "Mandatory" Must Enroll: All Medicaid and CHIP participants UNLESS Exempt or Excluded
- "Exempt" Permitted to Enroll:
  - Eastern Band of Cherokee Indians
  - Beneficiaries with serious ID/DD or Mental Illness (until Tailored Plans begin)

OUT: "Excluded" (*means Delayed)

- Medically needy
- Presumptive eligibility
- Emergency Medicaid
- HIPP program
- Family planning
- Individuals in prison
- MSP (MQB, QI-1)
- PACE
- CAP/C*
- CAP/DA
- Innovations Waiver*
- TBI Waiver*
- Nursing facility residents (90 days or more)*
- Dual eligible (Medicare)*
- Children in foster care*

What's Supposed to Happen

Individuals To Be Given a Choice of Plans…

- 60 days to select a PHP and primary care physician (PCP). Those who do not select a PHP will be auto-assigned to a PHP based on specific criteria.
- Plan members will have 90 days after plan coverage begins to change their PHP for any reason (whether person chose a plan or auto-assigned).
- Those who are Exempt can disenroll at any time (because enrollment is voluntary).
- Members can change PHPs only for good cause after 90 days run until the next year. Right to appeal if good cause denied.
- Members who do not choose a PCP will be auto-assigned by PHP. Able to change PCPs at least twice a year.

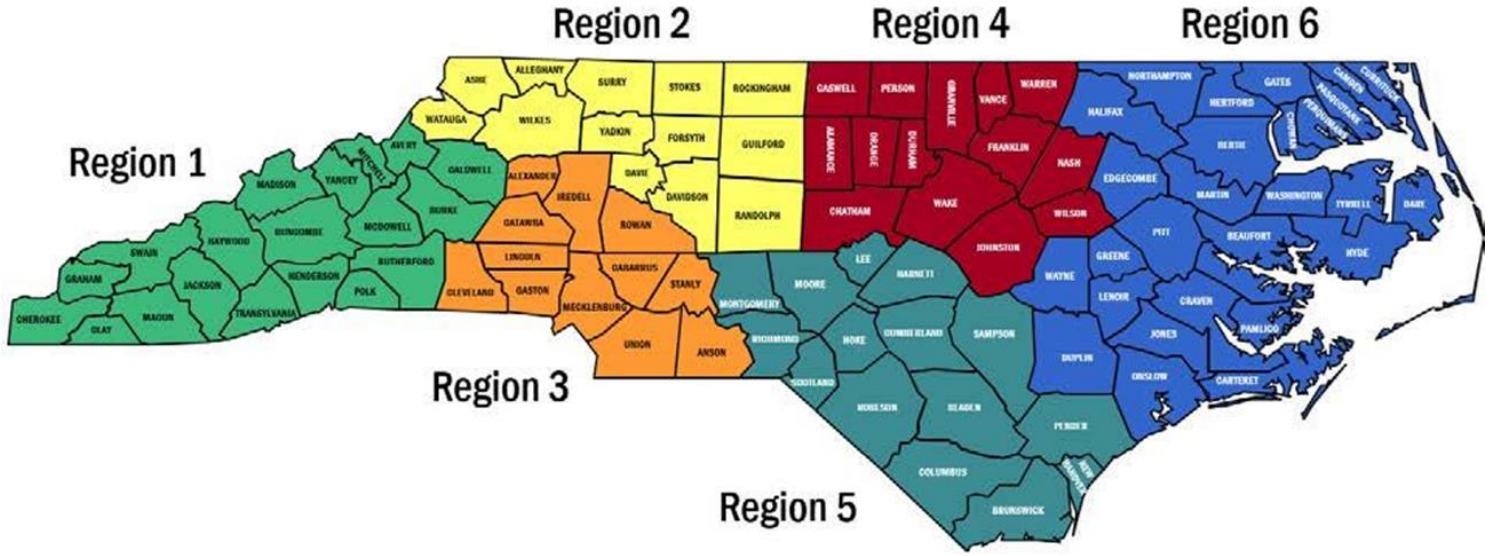
Standard Plans Selected by NC DHHS

Statewide:

- Blue Cross Blue Shield
- AmeriHealth Caritas
- United Health Care
- WellCare

Regions 3, 4 and 5:

- Carolina Complete Health Partnership of NC Medical Society and NC Community Health Center Association, with Centene (only Provider Led Entity chosen)

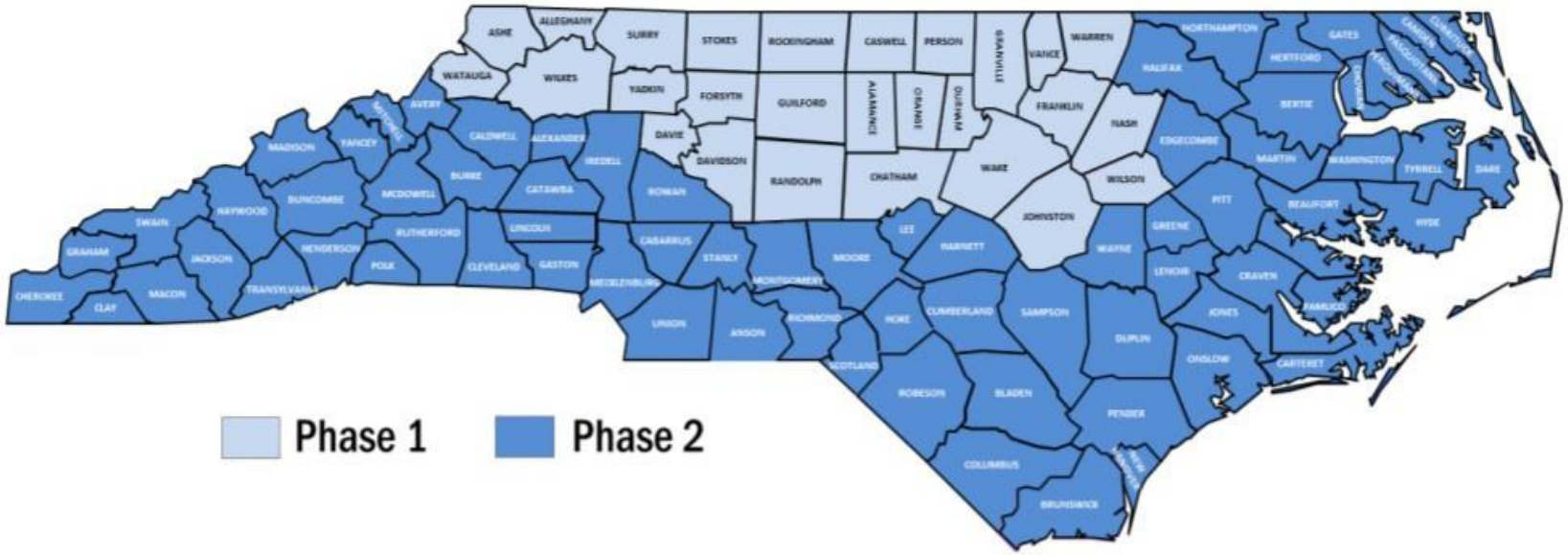


Note: Appeals have been filed by three unsuccessful bidders. Requests to delay implementation were denied.

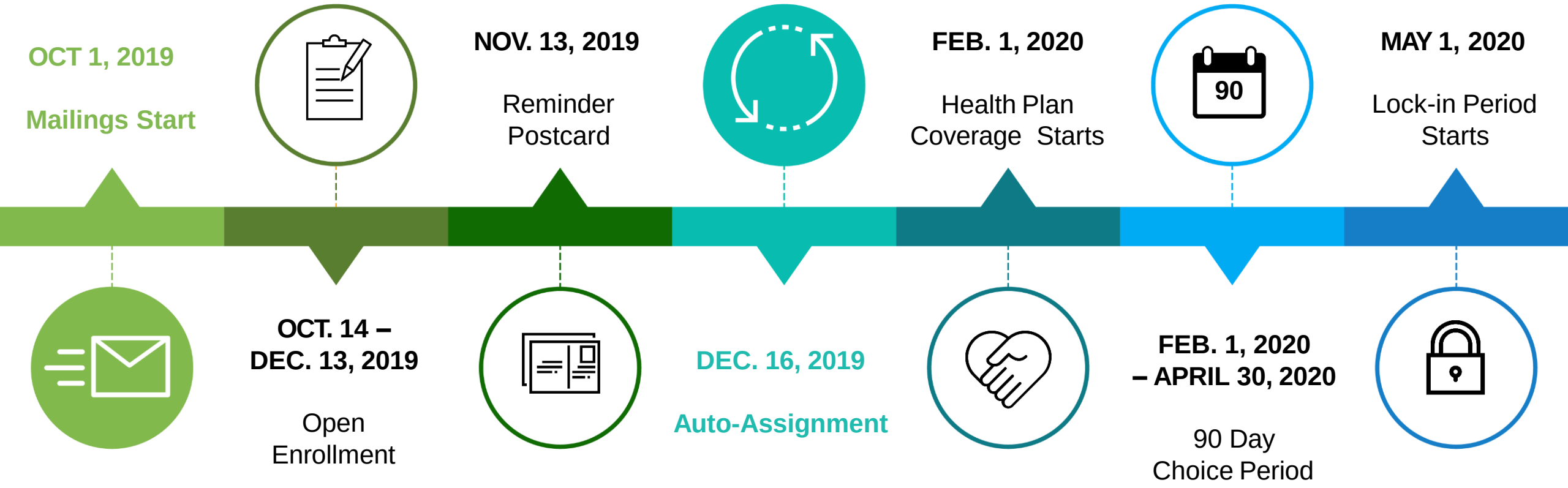
What's Supposed to Happen

NC Medicaid Managed Care Rollout Schedule

- **Phase 1: Regions 2 & 4**
  - Open Enrollment: July 15 – Dec. 13, 2019
  - Health Plan Coverage Starts: Feb. 1, 2020
- **Phase 2: Regions 1, 3, 5 & 6**
  - Open Enrollment: Oct. 14 – Dec. 13, 2019
  - Health Plan Coverage Starts: Feb. 1, 2020



Phase 2 Timing: Regions 1, 3, 5 and 6



Source: NC DHHS, Medicaid Managed Care Phase 1 Open Enrollment Webinar (July 15, 2019)

What's Supposed to Happen

What Happens to LME/MCOs?

- **Until July 2021:**
  - 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 2021, 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 least until 2025

What's Supposed to Happen

Two Types of Eligibility for Tailored Plans
(LME plus Medicaid Direct until July 2021)

- **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

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

Details at https://files.nc.gov/ncdhhs/BH-IDD-TP-FinalPolicyGuidance-Final-20190318.pdf

What's Supposed to Happen

Enrollment Broker 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
  - 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 plan.
- Assist in disenrollment/changing plans if needed.

What's Supposed to Happen

Covered Services

- PHPs will be required to cover all the same services offered through traditional FFS Medicaid (including nonemergency transportation) (RFP, Sec. V):
  - PHPs must use the state's Preferred Drug List (PDL) and formulary and state clinical policies for covered services*
  - PHPs must cover telemedicine;
  - Services may be no less in amount, duration and scope than services provided under FFS (with payment parity);
  - Must continue to cover all EPSDT services and conduct outreach to children due EPSDT visit (Medicaid children <21 only).
- **Transportation now PHP responsibility**. County DSS still responsible for excluded population.
- PHPs may offer "in lieu of" or "value-added" services after approval by DHHS.
- Cost sharing will remain the same ($1-$3 for Medicaid, $1-$25 for NCHC).
- Certain services carved out (remains in FFS), including dental services, eyeglasses, Local education agency (LEA) services, Children's Developmental Services Agency services.

*PHP can submit for approval alternative clinical coverage and prior authorization requirements to DHHS in Year 2

Behavioral Health Services

(RFP, Sec. VII, Attachment M; BH-IDD Tailored Plan Concept Paper)

Standard Plans	Tailored Plans/LMEs before July 2021
• 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	• 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

What's Supposed to Happen

Network Adequacy

(RFP, Sec. V; Network Adequacy in Sec VII, Attachment F)

- PHPs must meet DHHS' network adequacy standards (time/distance, and appt. wait times).
  - Must provide out-of-network care (at no additional cost to member), if cannot provide in-network care in a timely manner
  - 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.

What's Supposed to Happen

Care Management

(Sec. 13.3 of Section IX. Medicaid Managed Care Draft Rate book; Sec. V, VII Attachment M of RFP)

- 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 (LHDs)
    - LHDs will continue to provide care management for children with special health needs, and high-risk pregnancies for first 3 years (unless LHD chooses not to provide those services)
  - PHPs must provide care management to help people access nonmedical drivers of health, including housing, food, transportation and interpersonal safety; and must provide transitional care management for those moving from one clinical setting to another. PHP must 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)

What's Supposed to Happen

Beneficiary Protections

(RFP, Sec. V)

- Department must approve all marketing materials, PHPs cannot engage in direct solicitations.
- PHPs must provide language assistance services, including interpreters, translation services, and auxiliary aids.
- PHP must operate member services line, behavioral health crisis lines, and a nurse line.
- Grievance, appeal and state fair hearing procedures, including timeliness standards:
  - Appeals are for denials of benefit determinations or denials of payment or of disenrollment
  - Grievances include all other complaints against the PHP or providers (including quality of care, denial of expedited appeals, etc.)
- PHP must establish a member advisory committee, LTSS member advisory committee.
- PHP must facilitate transfers to different plans, or different providers, when appropriate.

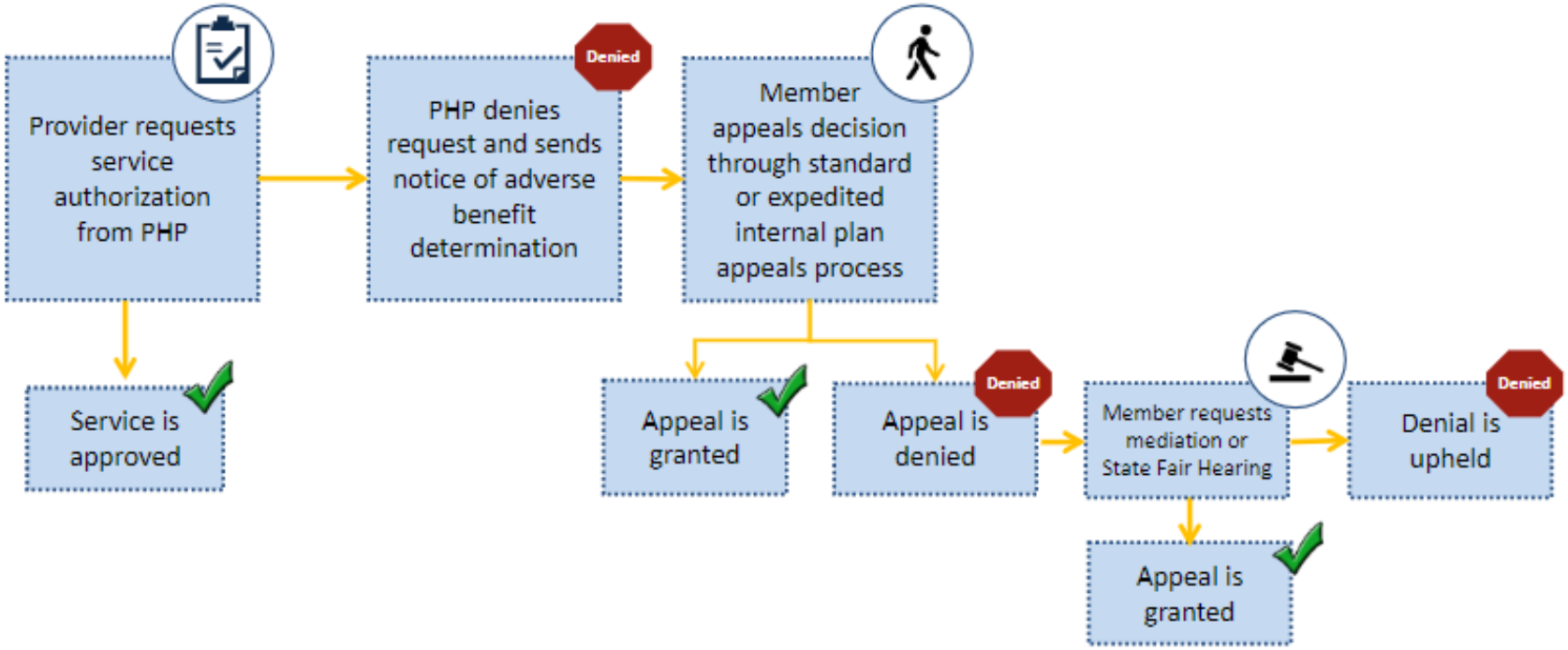
What's Supposed to Happen

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 being enrolled, 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.

What's Supposed to Happen

Appeals Process



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

What's Happened So Far

The Process So Far, Problems, New Developments

What's Happened So Far

The Enrollment Process So Far

- Letters/enrollment packets were mailed to beneficiaries in early July for Regions 2 and 4
- Enrollment broker website went live on June 28
- Enrollment Broker Toll Free number went live on June 28
- Plan websites went live during July
- DHHS announced Phone numbers for both providers and beneficiaries to report problems
- DHHS created SWAT team to work on problems

What's Happened So Far

The Enrollment Process So Far (cont.)

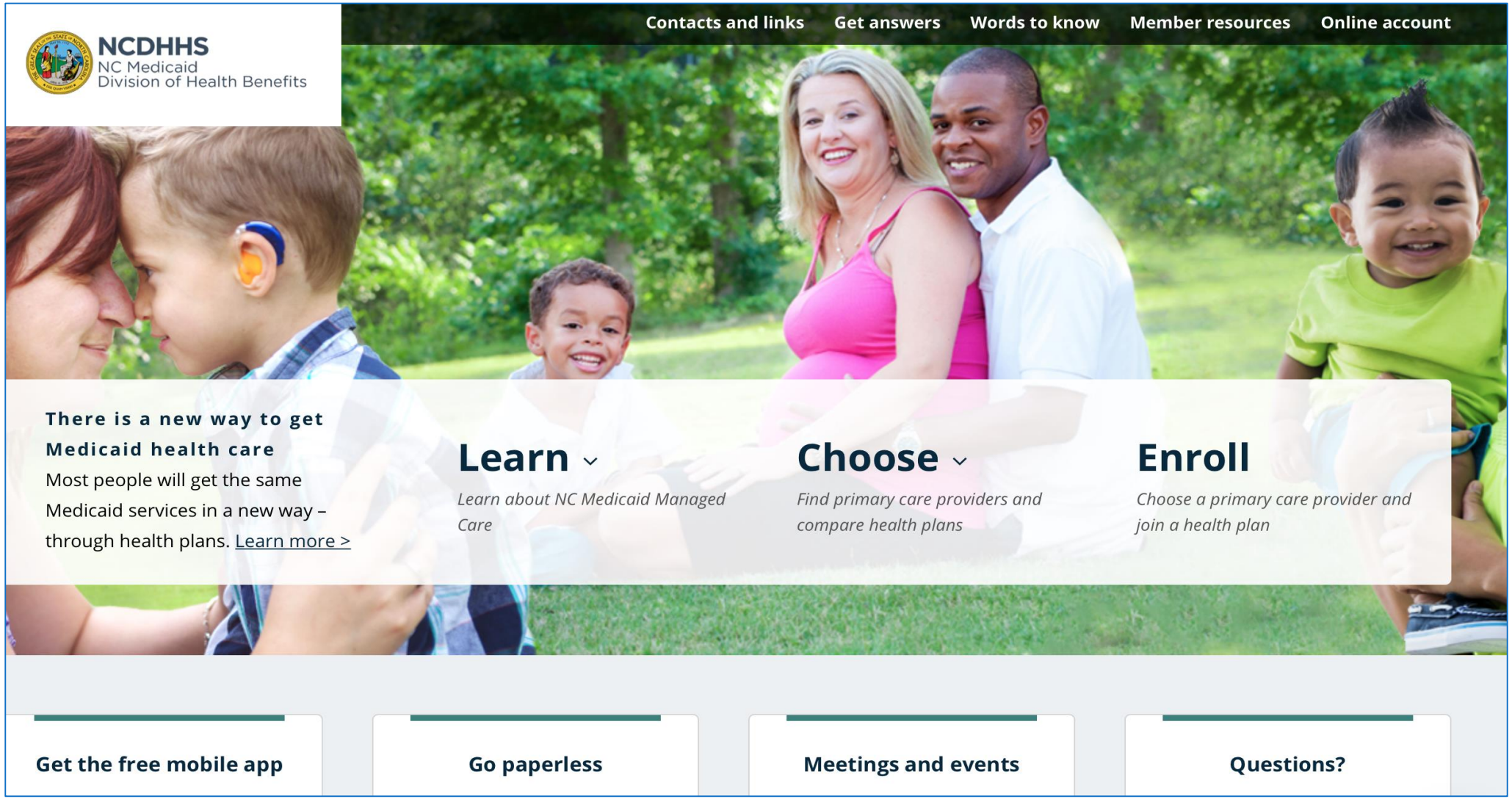
- DHHS delayed auto-assignment and go live dates for Regions 2 and 4.
- DHHS mailed notice of delay to Region 2 and 4 beneficiaries last week.
- Mailings to Phase Two beneficiaries THIS Week.

Sample Enrollment Letters:

- Mandatory: https://files.nc.gov/ncdma/1.-Enrollment-Packet-Mandatory-Notice.docx.pdf
- Exempt: https://files.nc.gov/ncdma/2.-Enrollment-Packet-Exempt-Notice.docx.pdf

Avenues for Enrollment

- Website: ncmedicaidplans.gov (English and Spanish)



What's Happened So Far

Avenues for Enrollment (cont.)

- NC Medicaid Managed Care mobile app
  - Available on iOS and Android
- Enrollment 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: Mon. – Sat. 7 a.m. – 5 p.m.
- Mail:
  NC Medicaid, PO Box 613, Morrisville NC 27560
- Fax: 1-833-898-9655
- In-Person:
  - Enrollment Broker Staff located at county DSS' and outreach sites

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Benefits

Health Plan Comparison Chart

All 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

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 compare added services, see the other side.

WellCare
Beyond Healthcare. A Better You.

1-866-799-5318
TTY: 711
wellcare.com/nc

7 a.m. to 6 p.m.,
Monday through Saturday

Statewide
(all 100 counties)

UnitedHealthcare Community Plan

1-800-349-1855
TTY: 711
uhccommunityplan.com/nc

7 a.m. to 6 p.m.,
Monday through Saturday

Statewide
(all 100 counties)

HealthyBlue

1-844-594-5070
TTY: 711
healthybluenc.com

7 a.m. to 6 p.m.,
Monday through Saturday

Statewide
(all 100 counties)

AmeriHealth Caritas North Carolina

1-855-375-8811
TTY: 1-866-209-6421
amerihealthcaritasnc.com

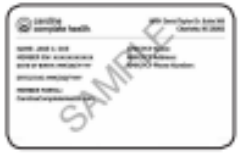
24 hours a day,
7 days a week

Statewide
(all 100 counties)

carolina complete health

1-833-552-3876
TTY: 711 or 1-800-735-2962
carolinacompletehealth.com

7 a.m. to 6 p.m.,
Monday through Saturday



Only available in these counties: Alexander, Anson, Bladen, Brunswick, Cabarrus, Catawba, Cleveland, Columbus, Cumberland, Gaston, Harnett, Hoke, Iredell, Lee, Lincoln, Mecklenburg, Montgomery, Moore, New Hanover, Pender, Richmond, Robeson, Rowan, Sampson, Scotland, Stanly, Union

More on back ▶▶▶

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.

MEDICAID EB COMP CHART ENG 19 0702

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

WellCare Beyond Healthcare. A Better You.	UnitedHealthcare Community Plan	HealthyBlue	AmeriHealth Caritas North Carolina	carolina complete health
Education ▪ $120 GED voucher	**Education** ▪ Life skills training	**Education** ▪ $50 annual gift card for school supplies ▪ GED exam voucher (up to $160 value) ▪ 24 hours of online tutoring for members ages 6-18, if qualify	**Education** ▪ GED exam voucher	**Education** ▪ GED exam practice supplies
Prenatal ▪ Up to $450 in rewards for baby products	**Prenatal** ▪ Free breast pump ▪ Up to $100 in rewards for baby products	**Prenatal** ▪ Up to $75 yearly rewards for doctor visits	**Prenatal** ▪ Home visits for high-risk pregnancy	**Wellness** ▪ Virtual care visits ▪ $75 yearly value in rewards ▪ $20 monthly for approved foods ▪ YMCA membership ▪ 10-week voucher for Weight Watchers® with 14 weeks of online tools
Wellness ▪ $75 yearly in rewards gift cards ▪ 20% CVS discount card ▪ 24-week voucher for Weight Watchers®	**Wellness** ▪ Up to $75 yearly in rewards gift cards ▪ 13-week voucher for Weight Watchers®	**Wellness** ▪ Yearly adult dental exam and cleaning ▪ $40 a month for groceries, if qualify ▪ 13-week voucher for Weight Watchers®	**Wellness** ▪ $75 yearly in rewards gift cards ▪ 13-week voucher for Weight Watchers®	**Youth** ▪ Boys & Girls Club membership for members ages 6-18
Youth ▪ Boy Scouts, Girl Scouts or 4-H Club membership	**Youth** ▪ $75 yearly for youth club membership	**Youth** ▪ $75 yearly for youth club membership	**Youth** ▪ Boys & Girls Club membership at participating locations for members under 19	**Other** ▪ $125 yearly for vision items for members ages 21 and older ▪ $30 quarterly value per household for over-the-counter drugs ▪ Home visits and supplies such as air filters and mattress covers for asthma
Other ▪ Hearing aid (up to $300 value) ▪ Up to $120 yearly value for over-the-counter drugs ▪ Cell phone with 1,000 monthly minutes, free texts and 1GB of data ▪ Rides to classes and events	**Other** ▪ $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, if qualify	**Other** ▪ Cell phone with monthly data, minutes and bonus minutes ▪ $20 Uber or Lyft gift card for college students for grocery stores, local events	**Other** ▪ Acupuncture, massage therapy, biofeedback ▪ Extra pair of glasses and eye exam every 2 years for members ages 21 and older ▪ Free meal delivery up to 7 days after hospital stay, if qualify ▪ Home visits and supplies such as pillow case covers for asthma ▪ Cell phone with 1,000 monthly minutes, free texts	

What's Happened So Far

Enrollment Packet Mailing Issues

Some Exempt Beneficiaries were erroneously sent Mandatory Letters.

- DHHS relied on data matches to determine who must enroll.
- State had no historical data on those new to Medicaid or to NC.
- State had limited data on other groups (e.g., those ages 0-3).
- State's methodology somewhat inconsistent with recent legislation.
- New Applicants and those due for Eligibility Review before February 2020 have not gotten letters. Unclear who will be mailed letters late and who will get no letter and be auto-assigned. For Phase 2, this affects DSS application approvals and those due for DSS review between 9/23/19 and 2/1/20 (over one-third of eligible population).
- *Almost 5% of mailings have been returned undelivered. DSS's supposed to update addresses so can be re-mailed but unclear when this will happen.

What's Happened So Far

8/2/19: Tailored Plan Update

- Responds to failure of DHHS to ID All Who are Exempt or Excluded.
- Expands criteria for exemption based on MH or DD diagnosis.
- Changes to Excluded those needing SA IOP or SA COT.
- Release of Raise Your Hand Forms for persons to self-ID as Exempt or Excluded.
- Persons enrolled in Standard Plans identified by DHHS as Exempt or Excluded will be disenrolled (moved to Fee For Service/LME services) effective the first of the month after they are identified. They will be able to request to be added back to Standard Plan.
- New procedure for persons enrolled in Standard Plan urgently needing LME services to expedite disenrollment/transfer and to backdate that change to date of request for disenrollment by provider/beneficiary.

Link to guidance: Behavioral Health I/DD Tailored Plan Memo on Eligibility and Enrollment Updates
https://files.nc.gov/ncdhhs/medicaid/BH-IDD-TP-Eligibility-Enrollment-Update-FINAL-20190716.pdf

What's Happened So Far

Raise Your Hand Form: Allows Beneficiaries to Self-ID as Exempt or Excluded

- Beneficiaries incorrectly IDed by data match as mandatory or whose circumstances change can request in writing that they be disenrolled (transferred from standard plan to FFS/LME).
- Care coordinators or care managers may assist beneficiaries in completing the beneficiary disenrollment request form.
- DHHS is contracting with Beacon Health Options (BHO) to assist with the Raise Your Hand process. DHHS (or BHO) will request information from providers to verify exemption (e.g. MH diagnoses or need for LME services).
- Provider can also request disenrollment/transfer on a different form.
- DHHS decision on request mailed to beneficiary.
- Decision can be appealed to Office of Administrative Hearings (OAH) within 30 days.
- Hundreds of requests already made but none processed yet.
- Find links to forms at:
- https://files.nc.gov/ncdhhs/medicaid/NC-MedicaidDirect-TransitionForm-Beneficiary-Attestation.docx
- https://files.nc.gov/ncdhhs/medicaid/NC-MedicaidDirect-TransitionForm-Provider-Attestation.docx

What's Happened So Far

Provider Networks Are Not Complete

- Many providers have been slow to enroll in plan, networks. Of 89,000 N.C. Medicaid providers, only 3000 had enrolled with standard plans as of July 15 (first day of open enrollment).
- Disputes over rates (e.g. care management), delay in posting provider manuals have contributed to delay.
- After enrolling, providers are not listed as enrolled until plan completes credentialing and sets up account to pay provider. This takes weeks.
- DHHS has announced Nov. 15 deadline for providers to enroll to (probably) be included in auto assignment.
- Beneficiaries should wait to enroll until provider information is more complete OR change plans during the 90 day grace period after coverage begins if needed. Can also change PCPs during that 90 day period or later.

What's Happened So Far

Problems Trying to Enroll

- Concerns re PHP marketing-misleading, added benefits, rewards.
- EB Website provider search tools were difficult to use (e.g. provider name display not consistent, filtering by specialty inaccurate).
- DHHS made changes to correct provider search problems but now can no longer search by doctor's name or for a specialist or hospital.
- Some Enrollment Broker staff lack complete/current information or need more training-e.g. telling beneficiaries to change doctors if PCP not listed.
- Plan websites slow to add required information.
- Beneficiary needs to create NCID to enroll electronically.
- Heads of Household were unable to enroll minors (corrected?).
- Authorized Representatives were unable to enroll beneficiary (corrected?).
- Other system problems making enrollment difficult.
- Only 57,000 beneficiaries have enrolled so far.

What's Happened So Far

Ombudsman Update

- Federal Medicaid regulations require a managed care ombudsman or similar beneficiary support for beneficiaries who need long term services and supports.
- DHHS promised an independent ombudsman to assist beneficiaries and help resolve problems.
- No bidders for March 2019 RFP.
- New RFP with changes posted in June.
  - 2 bids were submitted August 9, 2019.
  - Contract not yet awarded.
- Ombudsman will not go live until 2020.

What's Happened So Far

Ombudsman Update (cont.)

- Plan Handbooks and Enrollment letters have no information about Ombudsman.
  - Will state send a notice to all beneficiaries once Ombudsman contact info is available?
  - How soon will plans and Enrollment Broker update their materials?
- Until Ombudsman in place:
  - Enrollment Broker told to refer individuals to various agencies for assistance.
  - Medicaid Contact Center has had additional training to try to help beneficiaries.
  - DHHS internal response team.

What to Watch For

Potential Problems Ahead

What to Watch For

Possibility of Another Delay

- Governor vetoed both overall state budget and "mini-budget" bill to fund Transformation.
- House overrode both vetoes, pending in Senate.
- DHHS says it will again delay the February 1 go live date if no budget passes by mid-November.
- If budget veto is overridden, DHHS may not have sufficient funding to go live unless supplemental appropriations bill also passes.
- New motion pending in court to delay implementation.

What to Watch For

Feb. 2020 Transition of Care

- DHHS has asked PHPs to honor existing service authorizations for first 90 days (or until authorization expires if sooner). But unclear if this will happen.
- Will PHPs continue services pending appeal if they shorten existing authorizations and terminate services?
- What happens to prior authorization requests pending on Feb. 1?
- What happens to beneficiary appeals of denials of prior authorization pending on Feb. 1?
- Will care be interrupted if move from PHP back to LME/FFS?

What to Watch For

Enrollment Issues

- Will Enrollment Broker be able to handle increased demand from no staggered rollout?
- Is beneficiary Exempt from enrolling in managed care? Required to enroll anyway? Told of right to disenroll at any time?
- If beneficiary w/severe MI/DD files request to disenroll from managed care, decision promptly issued in writing with appeal rights?
- Are plan marketing practices and materials accurate, fair?
- Is plan's provider directory accurate? Are the providers listed actually accepting new Medicaid patients?

What to Watch For

Enrollment Issue (cont.)

- Is Enrollment Broker easily accessible and helpful to beneficiary in choosing a plan? In requesting exemption or to change plan?
- Is Enrollment Broker providing current, accurate, unbiased information?
- Will a beneficiary with good cause be able to change plans after 90 days? Will plan and Enrollment Broker tell her this?
- Will a request to change plans be acted on properly/promptly by Enrollment Broker and plans?

What to Watch For

Enrollment (cont.)

- If mental health condition worsens so that need for LME services, will beneficiary be smoothly transitioned from standard plan to LME without interruption in care or delay in getting needed services?
- If beneficiary begins receiving Medicare or starts getting CAP-DA or CAP-C services, will she be promptly automatically disenrolled from managed care without disruption?
- How will PHPs auto assign to PCPs??

What to Watch For

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 and providers meet Section 1557 requirements for persons with Limited English Proficiency (LEP) or a disability (e.g., translator, written materials, assistance meeting requirements)?
- Do plan and providers provide services in culturally competent way (including to persons with different sexual orientation)?

What to Watch For

Access to Care Issues

- 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 with nearby appropriate providers for all services needed, including specialty care, in home care, mental health treatment?
- Will plans tell beneficiary when a right to out of network care?
- Will beneficiaries be denied out of network provider where plan cannot provide ready 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?

What to Watch For

Access to Care Issues (cont.)

- Will plan cover all services required under state plan plus any service that can be covered under EPSDT?
- Will plan meet mental health parity requirements in coverage policies and decisions?
- Will plan 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?

What to Watch For

Denial of Care Issues

- 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?

What to Watch For

Denial of Care Issues (cont.)

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

What to Watch For

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?

What to Watch For

Appeal Process Issues (cont)

- 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?

Resources for Beneficiaries & Advocates

Who Can Help and What Are They Supposed to Do?

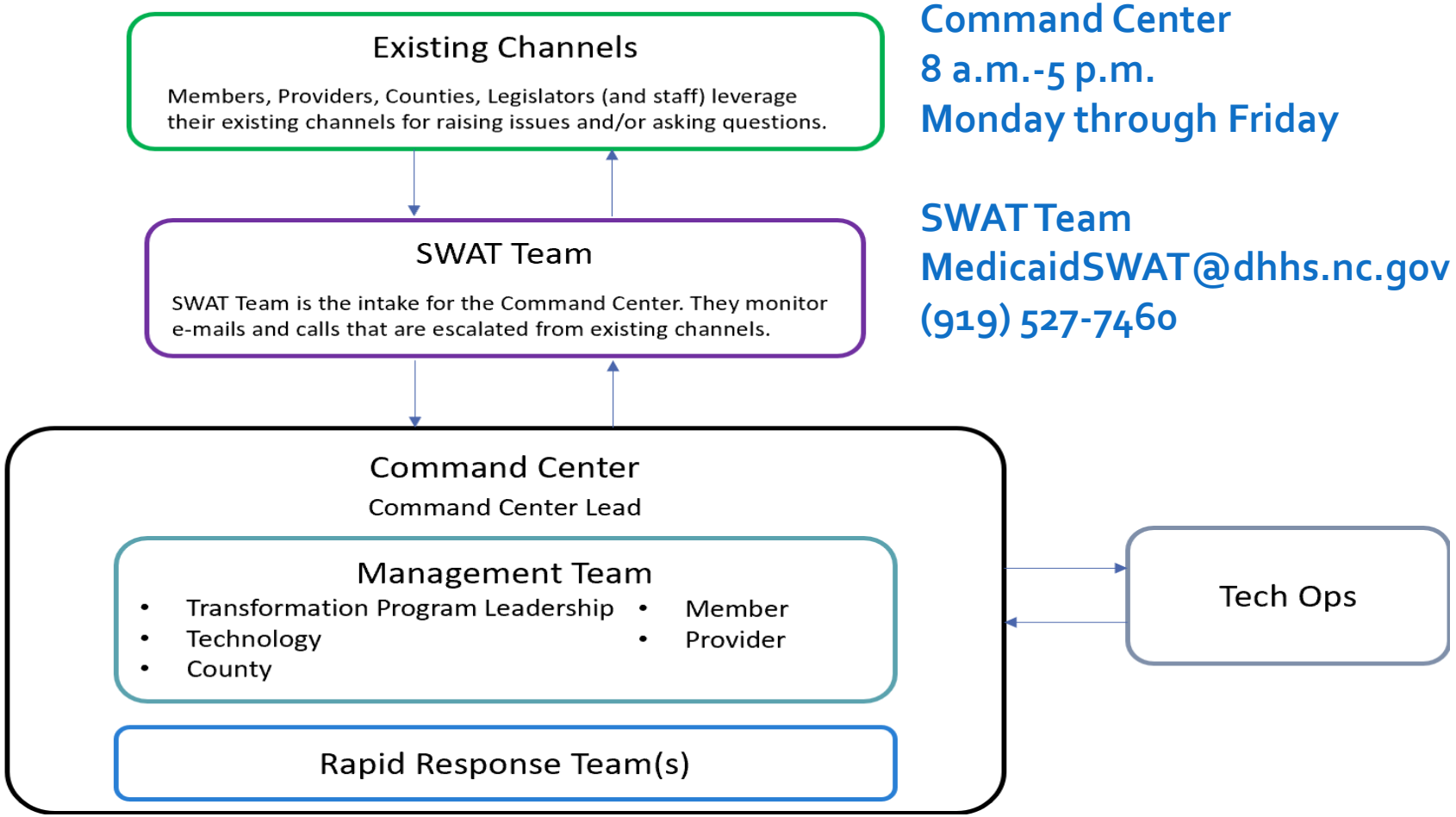
Resources for Beneficiaries & Advocates

Issue Resolution

- Raising questions and issues is encouraged
  - **Providers:** NCTracks:
    - 800-688-6696
  - **Beneficiaries:** Medicaid Contact Center:
    - 833-870-5500
  - **Counties:** NC FAST:
    - 919-813-5400
- When needed, issues can be escalated to DHHS SWAT team
  - by calling: 919-527-7460; or
  - Emailing: MedicaidSWAT@dhhs.nc.gov
- DHHS staff can escalate issues to SWAT team focused on problem identification and resolution

Resources for Beneficiaries & Advocates

Issue Resolution



SWAT Team and Command Center
8 a.m.-5 p.m.
Monday through Friday

SWAT Team
MedicaidSWAT@dhhs.nc.gov
(919) 527-7460

Resources for Beneficiaries & Advocates

Questions or Concerns?

- If beneficiaries have questions or problems, they should contact one of the following organizations for free legal advice/assistance:
- Charlotte Center for Legal Advocacy (Mecklenburg, Union, and Cabarrus County)
  - **1-800-438-1254** www.charlottelegaladvocacy.org
- Becca Friedman: RebeccaF@charlottelegaladvocacy.org
  - Direct Line: 908-202-7349
- Disability Rights NC (statewide for persons with disabilities)
  - **1-877-235-4210** www.disabilityrightsnc.org
- Pisgah Legal Services (Buncombe, Madison, Transylvania, Henderson, Polk and Rutherford County))
  - **1-800-489-6144** www.pisgahlegal.org
- Legal Aid of NC (statewide except counties listed above)
  - **1-866-219-LANC (5262)** www.legalaidnc.org

Resources for Beneficiaries & Advocates

For More Information

Provider Playbook: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care

- NC Justice Center Medicaid Transformation subpage (find materials & previous webinar): https://www.ncjustice.org/projects/health-advocacy-project/medicaid-expansion/medicaid-transformation/
- Provider trainings: https://medicaid.ncdhhs.gov/nc-medicaid-managed-care-training-courses
- NC Medicaid Transformation Policy papers: https://www.ncdhhs.gov/policy-papers
- Advanced Medical Home information: https://medicaid.ncdhhs.gov/advanced-medical-home
- County Playbook: https://medicaid.ncdhhs.gov/county-playbook-medicaid-managed-care
- Medicaid managed care Requests for Proposals (for PHPs) and related resources: https://www.ncdhhs.gov/request-information

Resources for Beneficiaries & Advocates

WHAT CAN YOU DO?

Spread the word!

Medicaid Transformation is coming!

Help clients understand their options!

Questions?

Seeing Problems?