



Medicaid Managed Care  
Proposed Concept Paper

Beneficiaries in  
Medicaid Managed Care

North Carolina Department of  
Health and Human Services

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*This document is part of a series of concept papers that the Department of Health and Human Services scheduled for release from late 2017 through early 2018 to provide additional details to stakeholders regarding the transition of North Carolina Medicaid and NC Health Choice programs to a predominantly managed care model. This technical paper is written primarily for providers and health plans that will participate directly in Medicaid managed care, but anyone may respond and provide feedback to the Department, including beneficiaries, advocates or other interested parties. Some topics mentioned in this document may be covered in more detail in other concept papers in the series. For more information on the Department’s proposal, stakeholders are encouraged to review the Amended North Carolina Section 1115 Demonstration Waiver Application and previously released concept papers available at [ncdhhs.gov/nc-medicaid-transformation](http://ncdhhs.gov/nc-medicaid-transformation).*

*Input is welcome and appreciated. Send comments to [Medicaid.Transformation@dhhs.nc.gov](mailto:Medicaid.Transformation@dhhs.nc.gov).*

## I. Introduction

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The Department of Health and Human Services (the Department) will ensure that Medicaid and NC Health Choice beneficiaries, their families and caregivers are supported in the transition to Medicaid managed care throughout the enrollment process, including selecting a prepaid health plan (PHP), primary care provider (PCP) and/or advanced medical home (AMH), and resolving potential grievances or appeals. The Department will ensure beneficiaries and their families have the tools and resources to access care and experience a smooth transition from the predominantly fee-for-service delivery system<sup>1</sup> to managed care.

North Carolina's Medicaid and NC Health Choice programs currently provide health coverage to two million North Carolinians. This includes one in two births, two in five children, three in five people residing in nursing homes, and thousands of individuals with disabilities. As required by Session Law 2015-245, as amended, North Carolina is transitioning its Medicaid and NC Health Choice programs for most beneficiaries from a predominantly fee-for-service delivery system to a system that is largely managed care. North Carolina envisions an innovative, whole-person centered, well-coordinated system of care that addresses medical and non-medical drivers of health. The Department will implement Medicaid managed care in a way that advances high-value care, improves population health, engages and supports providers, and establishes a sustainable program with predictable costs.

After transitioning to managed care, the Department expects that in total approximately 90 percent of current beneficiaries will ultimately be required to enroll in prepaid health plans (PHPs, which are comprehensive Medicaid managed care plans). Current North Carolina Medicaid and NC Health Choice beneficiaries enrolled in the fee-for-service program, called the "crossover" population, are scheduled to transition to PHPs beginning in 2019. There are limited exceptions to mandatory enrollment in the managed care program for certain populations that may be better served outside of managed care. These populations, described in Table 1, are either exempt or excluded.

"Exempt" populations may choose to enroll in fee-for-service or PHPs, and include members of federally recognized tribes. North Carolina consulted with its only federally recognized tribe, the Eastern Band of Cherokee Indians, and concluded that members of federally recognized tribes will benefit from having the choice between Medicaid fee-for-service or enrollment in a PHP. "Excluded" populations must receive health benefits through fee-for-service or other current delivery system.

Finally, the Department envisions that, with legislative approval, certain targeted populations with complex and unique health care needs will phase into the managed care program over a four-year period as the PHPs become capable of serving more complex populations. Under this vision, some of the populations that could be delayed include children in foster care and adoptive placements, Medicaid-only Community Alternatives Programs for children (CAP/C) and disabled adults (CAP/DA) beneficiaries, and Medicaid-only beneficiaries in a nursing facility for 90 days or more.

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<sup>1</sup> The Department currently has a managed care delivery system for behavioral health and intellectual and developmental disabilities services through the local management entities/managed care organizations (LME/MCOs). "Fee-for-service," as used throughout this concept paper, refers to only physical health services.

**Table 1. Populations Exempt and Excluded from PHPs**

Exempt Populations
Members of federally recognized tribes <sup>2</sup>
Excluded Populations <sup>3</sup>
<ul style="list-style-type: none"><li>• Beneficiaries dually eligible for Medicaid and Medicare<sup>4</sup></li><li>• Program of all-inclusive care for the elderly (PACE) beneficiaries</li><li>• Medically needy beneficiaries</li><li>• Beneficiaries eligible for only emergency services</li><li>• Presumptively eligible enrollees during the period of presumptive eligibility</li><li>• Health insurance premium payment (HIPP) beneficiaries</li><li>• Family planning beneficiaries</li><li>• Prison inmates</li></ul>

To ensure successful implementation of managed care, Medicaid and NC Health Choice beneficiaries will be transitioned from fee-for-service into PHPs by region. The Department is planning a two-phase approach, with corresponding open enrollment periods for each subset of the crossover population. When the PHP contract is awarded, the Department will determine which regions will be selected for Phase 1 or Phase 2 of the managed care rollout. This selection will depend on factors including, but not limited to, the number of beneficiaries in the regions, having a mix of predominantly urban and rural counties in Phase 1, and the mix of commercial plans and provider-led entity PHPs. If possible, the Department will select contiguous regions to minimize beneficiary or provider confusion. Phase 2 is expected to occur in the remaining regions three to five months after initial launch.

## II. Eligibility and Enrollment

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The Department wants applicants to experience a simple, timely and user-friendly eligibility and enrollment process that will be available online, by telephone, in-person or by mail. Over time, the Department envisions that beneficiaries will apply, receive a determination, select a PHP, and an AMH and PCP in one sitting. Much work must be done at the county and state levels to realize the vision of an integrated, web-enabled platform selection process.

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<sup>2</sup> North Carolina consulted with its only federally recognized tribe – the Eastern Band of Cherokee Indians (EBCI) – and concluded that members of federally recognized tribes will benefit from having the choice between Medicaid fee-for-service or enrollment in a PHP. The Department is in discussions with EBCI on pathways to becoming the first Native American managed care entity in the country, and is exploring options for EBCI enrollees who elect to participate in PHPs. The Department and EBCI will continue to collaborate on the development of a “tribal option” that considers and addresses the unique cultural, behavioral health and medical needs of the EBCI. The tribal option may not initially be a full-risk health plan; however, EBCI and the Department are considering the feasibility of a future full-risk or partial-risk arrangement. Current estimates indicate there are approximately 4,000 EBCI members enrolled in Medicaid.

<sup>3</sup> Session Law 2015-245, as amended, excludes all populations listed in this column except family planning beneficiaries and prison inmates. The Department is seeking authority from the General Assembly to exclude those two populations.

<sup>4</sup> Beneficiaries who are dually eligible for Medicare and Medicaid are currently excluded (see Table 1). The Department is contemplating phasing in dually eligible members to managed care, pending additional authority from the General Assembly.

## Medicaid Eligibility Determination/Interface with DSS/EBCI Public Health and Human Services

Managed care makes no changes to eligibility or post-eligibility treatment of income. The Department will retain current enrollment limits for the 1915(c) Innovations, Traumatic Brain Injury, CAP/C and CAP/DA waivers.

When PHP contracts begin in 2019, Medicaid and NC Health Choice applications and redeterminations may continue to be submitted online, through the mail or in-person at county Departments of Social Services (DSS) offices<sup>5</sup>. DSS offices will continue to process and determine eligibility for potential beneficiaries, and update eligibility information such as address or other contact information. This will mean that initially upon PHP launch, when beneficiaries need to update their addresses, they will need to contact the county DSS office. Over time, the Department will provide Medicaid and NC Health Choice applicants and their families with a simple, streamlined and integrated eligibility and enrollment process that ensures the timely and accurate determination of Medicaid eligibility in real time in NC FAST or ePASS system. Once determined eligible, beneficiaries will be redirected in real time within the same session to the PHP selection system managed by the enrollment broker. The enrollment broker will offer choice counseling, enroll beneficiaries in PHPs, maintain and update enrollment information such as PHP selection. The enrollment broker will assist beneficiaries by transferring them to their county DSS office to keep the beneficiary's eligibility information updated. Medicaid beneficiaries may reach out to their county DSS office with questions about Medicaid managed care or enrollment. The Department will ensure that county DSS and Public Health and Human Services (PHHS) caseworkers receive the education and training needed to be equipped to assist beneficiaries and refer them to the enrollment broker for choice counseling.

### Enrollment Broker

To support implementation of the Medicaid managed care program, the Department will contract with an independent, third-party enrollment broker to ensure that Medicaid applicants understand the benefits in managed care and receive choice counseling as needed to select a PHP. As defined in 42 C.F.R. § 438.810, the enrollment broker will be expected to meet independence and freedom of conflict requirements and will be required to remain impartial, without conflict of interest, when assisting beneficiaries with PHP, and AMH and PCP selection.

At managed care launch, the Department plans to begin implementing a series of technical and process changes to significantly improve the overall beneficiary experience when interacting with DHHS. These changes will be implemented on the State and partners' systems. For example, the enrollment broker in the future will leverage a plan selection tool that will provide beneficiaries with an eligibility determination in real time in the NC FAST or ePASS systems, and be redirected, also in real time, within the same session to the plan selection system.

The enrollment broker's plan selection tool will tailor the presentation of plans available to beneficiaries based on a variety of factors—the beneficiary's location, personal health care needs, exempt or non-exempt status (a member of federally recognized tribe), provider network, PHP enrollment history—all targeted at helping beneficiaries select a PHP that best fits their needs. The Department will work with the enrollment broker to define the plan selection factors, data transmission interfaces, application program interfaces and security requirements to facilitate the exchange of PHP selection information among systems.

To support beneficiary education and PHP choice counseling during the transition to managed care, the Department will ensure that beneficiaries have the information necessary to select the PHP and AMH/PCP that

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<sup>5</sup> References to county DSS offices in this paper include EBCI

will meet their needs. The enrollment broker will be required to interact with North Carolina's 100 county DSS and EBCI PHHS offices, to provide seamless eligibility and enrollment experience for beneficiaries.

As the choice counselor, the enrollment broker will assist individuals with selecting and changing plans as needs arise. The enrollment broker will be expected to provide managed care resources, education and assistance, including:

- Explanation of the North Carolina Medicaid managed care program;
- Services covered under the North Carolina Medicaid managed care program, including those that can be furnished without referral and how to obtain them;
- List of PHPs available to an individual, based on geography and other criteria;
- Comparison charts that explain the distinctions between PHP options;
- Instructions on how and by what deadline to select a plan;
- Benefits that are North Carolina Medicaid covered services, but are carved out of the Medicaid managed care program under Session Law 2015-245, as amended, and how to obtain such benefits;
- Advantages to beneficiaries to improve health and wellness, such as smoking cessation;
- Education about non-emergency medical transportation and how to access the benefit;
- Preserving relationships with current providers for continuity of care;
- Process for selecting and changing a PHP (including plan selection period and choice window);
- Process for selecting and changing a PCP during and after enrollment;
- Medicaid rules for "with cause" and "without cause" disenrollment;
- Disenrollment process, including:
  - Opportunities for disenrollment or changing PHP; and
  - Types of requests processed by the enrollment broker and those that are processed by the Department;
- Information about beneficiary and potential beneficiary rights to appeal and instructions on how to appeal managed care enrollment and disenrollment request decisions;
- Information about the ombudsman program;
- Information on social determinants of health screening and health risk screening; and
- Any additional topic or subject the enrollment broker believes beneficiaries or their authorized representatives would benefit from or would improve the customer experience.

The enrollment broker will be expected to demonstrate its understanding of the unique needs of North Carolina Medicaid beneficiaries, including carrying out enrollment functions in a culturally competent manner, accounting for different literacy levels, and accommodating beneficiaries or authorized representatives with developmental or physical disabilities (e.g., modifying scripts or materials appropriately or communicating with legally responsible persons).

The enrollment broker will facilitate enrollment and education services, updating information as changes occur with the managed care program, populations or geographic regions. In addition to conducting enrollment activities, the enrollment broker will provide education and outreach to Medicaid and NC Health Choice managed care eligible beneficiaries. Beneficiary outreach and education will include, but is not limited to:

- Managed care education;
- Pre-enrollment announcements and reminders;
- Enrollment process education;
- PHP selection;
- PCP/AMH selection;
- Disenrollment;
- Development of materials to assist beneficiaries with enrolling; and
- Hosting local events.

In addition to maintaining a call center to assist beneficiaries, the enrollment broker will be expected to have a community presence. Depending on costs, the Department may require that the enrollment broker maintain a physical presence in county DSS and Tribal offices to assist staff with answering possible questions related to the managed care program and processes associated with enrollment, disenrollment or changing a PHP. The Department will expect the enrollment broker to coordinate with the ombudsman program and PHP member services to assist beneficiaries through the managed care system.

## Enrollment in Managed Care

To support the Department's transition to and ongoing operation of the managed care program, the enrollment broker will provide beneficiary support to meet the needs of the Medicaid and NC Health Choice population. The enrollment broker will support five populations: 1) crossover population with open enrollment; 2) new beneficiaries after crossover open enrollment closes; 3) beneficiaries at redetermination; 4) special populations to be phased into managed care after initial crossover population enrollment; and 5) populations exempt from managed care; e.g., member of federally recognized tribe.

### **Crossover Population**

The Department will transition approximately 1.5 million beneficiaries through a two-phase rollout, with an anticipated Phase 1 rollout from fee-for-service to the managed care program targeted for July 1, 2019 (or a date determined by the Department).<sup>6</sup> Beneficiaries who transition from fee-for-service to managed care are

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<sup>6</sup> Pending the approval of North Carolina's amended Section 1115 Waiver application and supporting legislation.

referred to as the “crossover population.” Phase 2 rollout will use the same approach but with different dates to be determined upon PHP contract award.

- To support beneficiary choice, the Department will offer the crossover population 60-day open enrollment period. The open enrollment period will begin no later than 105 days before the managed care launch.
- During the open enrollment period, the enrollment broker will proactively describe its services to beneficiaries, including managed care education, and PHP and AMH/PCP selection support. Outreach will be by phone, internet, by mail and in-person.
- If a beneficiary does not select a PHP during open enrollment as defined by the Department, the Department will auto-assign the beneficiary to a PHP based on an algorithm described below.
- After PHP coverage becomes effective, beneficiaries will have a 90-day choice period to change their PHP before being locked into that PHP until their annual redetermination date, if the change qualifies as being “with cause,” or if involuntarily disenrolled due to no longer meeting eligibility requirements or PHP termination. The enrollment broker will provide choice counseling and support PHP selection to beneficiaries during the 90-day choice period.
- Table 2 provides a proposed timeline for the crossover population as defined by the Department in *Proposed Crossover Population Timeline*.

**Table 2. Proposed Phase 1 Sample for the Crossover Population**

Key activity	Proposed date
Soft launch of enrollment broker call center/website to support choice counseling and PHP selection	Jan. 1, 2019
Open enrollment period begins	March 15, 2019
Open enrollment period ends	May 15, 2019
PHP effective date <sup>7</sup>	July 1, 2019
90-day choice period begins	July 1, 2019
Beneficiary may change PHPs without cause	July 1 – Sept. 29, 2019
90-day choice period ends	Sept. 29, 2019
Member may change PHPs with cause and at redetermination	Ongoing

### **New Beneficiaries After Crossover Open Enrollment During Phase 1**

New beneficiaries applying and being determined eligible for Medicaid or NC Health Choice after the crossover open enrollment period closes will be given an opportunity to select a PHP and AMH/PCP as part of the Medicaid or NC Health Choice application.

- If a beneficiary does not select an PHP as part of the Medicaid or NC Health Choice application, the beneficiary will be auto-assigned to a PHP.
- After PHP coverage becomes effective, beneficiaries will have a 90-day choice period to change their plan before being locked into that plan until their annual redetermination date, if the change qualifies

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<sup>7</sup> If a beneficiary does not select a PHP during open enrollment, the Department will auto-assign a PHP and communicate the plan to the beneficiary.

as being “with cause,” or if involuntarily disenrolled due to no longer meeting eligibility requirements or PHP termination. The enrollment broker will provide choice counseling and support PHP selection to beneficiaries during this 90-day choice period.

**Table 3. Phase 1 Sample New Beneficiary Timeline Example**

Key activity	Example date
New beneficiary applies and is determined eligible for Medicaid without making PHP selection	Nov. 1, 2019
Beneficiary auto-assigned to PHP	Nov. 1, 2019
90-day choice period begins	Nov. 1, 2019
Beneficiary may change PHPs without cause	Nov. 1, 2019 – Jan. 30, 2020
90-day choice period ends	Jan. 30, 2020
Member may change PHPs with cause or at redetermination	Ongoing

### Beneficiaries at Redetermination

“Redetermination” is the annual review of beneficiaries’ income, assets and other information by the Department and county DSS to confirm eligibility for Medicaid and NC Health Choice. Beneficiaries redetermined to be eligible will have an opportunity to select a new PHP through a notice from the Department.

- Beneficiaries who are redetermined to be eligible will be auto-assigned a PHP by the Department according to the auto-assignment process, likely the same PHP from the prior year, provided the PHP continues to participate in the program.
- Beneficiaries will be offered a 90-day choice period to select a new PHP, if wanted. The enrollment broker will provide choice counseling and support PHP selection to beneficiaries during the 90-day choice period.
- Beneficiaries determined to no longer be eligible will be notified by the Department and disenrolled from the PHP effective on their last eligibility date.

### Special Populations to be Phased into Managed Care after Crossover Population Enrollment

The Department anticipates phasing-in special populations into the managed care program over a period of four years, with approval from the NC General Assembly, after Phase 1 launch. The Department will seek input from the enrollment broker and other stakeholders for an open enrollment period for each new population transitioned into the managed care program over the potential duration of the contract (including extensions), similar to what is described above for the crossover population. The Department recognizes there may be essential needs unique to these special populations and will work with stakeholders to define educational materials or operational processes that meet those needs.

- **BH I/DD TP Populations.** The Department is working with the General Assembly such that beneficiaries with a serious mental illness, a serious emotional disturbance, a substance use disorder or an intellectual/developmental disability will have a delayed mandatory enrollment into PHPs during the transition period between the initial launch of standard plans and the subsequent launch of BH I/DD TPs<sup>8</sup>. During the transition period, these beneficiaries will have the option to voluntarily enroll in a

<sup>8</sup> See the [“Behavioral Health and Intellectual/Developmental Disability”](#) concept paper on the Medicaid Transformation website for more information.:

standard plan. Also during the transition period, beneficiaries with a serious mental illness, a serious emotional disturbance, a substance use disorder or an intellectual/developmental disability may opt in or out of managed care and back into fee-for-service (and LME-MCOs as applicable for behavioral health and I/DD services) at any time.

To support beneficiaries with a serious mental illness, a serious emotional disturbance, a substance use disorder or an I/DD, the enrollment broker will, at a minimum:

- Accept BH I/DD TP eligibility information from the Department and use to support choice counseling and PHP selection;
  - Accept from the Department updates on beneficiaries who the Department determines to be eligible to enroll in BH I/DD TP either through historical claims analysis or other means;
  - Train staff to provide consumer-specific supports to BH I/DD TP population to support plan choice;
  - Provide choice counseling to enrollees who meet the BH I/DD TP eligibility criteria and explain the differences in covered BH and I/DD services between standard plans and LME-MCOs, and that the standard plan enrollees will not be able to access services covered by only the LME-MCOs; and
  - After launch of BH/IDD TPs, accept and act on requests for transfers from standard plans to BH I/DD TPs as allowable by the Department.
- **Exempt populations.** Members of federally recognized tribes are exempt from mandatory enrollment in managed care. Assignment of members of federally recognized tribes to plans will be incumbent on certain criteria including, but not limited to, the existence of a tribal option and enrollee geographic location.
    - The enrollment broker will provide choice counseling to these beneficiaries and support PHP, AMH/PCP selection in a manner similar to the other populations defined above, based on when the exempt beneficiary becomes eligible for Medicaid or NC Health Choice and the existence of a tribal option.
    - The enrollment broker will be expected to provide the following to managed care exempt members of federally recognized tribes, at a minimum:
      - Accept tribal beneficiary information from the Department and use to support choice counseling and PHP selection;
      - Train their staff in providing culturally sensitive and consumer-specific supports to the tribal population to support plan choice; and
      - Provide choice counseling to enrollees identified as members of federally recognized tribes:
        - On the differences between managed care and fee-for-service including the tribal option if available; and
        - That members of federally recognized tribes will default into the tribal option if they live in the geographic area covered by the tribe but may choose to change plans or delivery system (e.g. FFS vs. managed care) at any time.

- That if the tribal option is not available, that members of the federally recognized tribe will default into fee-for-service and may choose to remain in fee-for-service or choose a PHP.

## Auto-Assignment Factors

Auto assignment is the process where the Department enrolls a beneficiary into a PHP if the beneficiary has not selected a PHP within a specified time defined by the Department. During the crossover transition from the fee-for-service to the managed care program, the beneficiary will be provided an open enrollment period where the beneficiary can actively choose which PHP is appropriate for him or her. If after open enrollment, the beneficiary has not chosen a PHP, the Department will use an auto-assignment process to attempt to match the beneficiary with the best PHP for that person based on information available to the Department.

To support auto assignment, the Department will develop auto-assignment algorithms to be used for beneficiaries determined to be Medicaid-eligible and who did not select a PHP during their choice period or Medicaid application process. The auto-assignment algorithm may be used in other instances deemed appropriate by the Department or as required by state or federal law.

- The auto-assignment algorithm for the crossover population is defined according to the following components, in this order:
  1. Whether beneficiary is a beneficiary of a special population (e.g., foster care, BH I/DD TP eligible, a member of a federally recognized tribe);
  2. Beneficiary's geographic location;
  3. Historic provider-beneficiary relationship if available in recent claim data;
  4. Plan assignments for other family members; and
  5. Equitable plan distribution with enrollment subject to PHP enrollment ceilings and floors.
- The auto-assignment algorithm for beneficiaries enrolled after crossover open enrollment is defined according to the following components, in this order:
  1. Whether beneficiaries are members of a special population (e.g., foster care, BH I/DD TP);
  2. Plan assignments for other family members;
  3. Beneficiaries' geographic location;
  4. Previous PHP enrollment during previous 12 months (for those who have churned on/off Medicaid managed care); and
  5. Equitable plan distribution with enrollment subject to PHP enrollment ceilings and floors.
- Auto assignment may also be used in the following instances:
  1. Redetermined Medicaid managed care beneficiaries, including those whose plans have been discontinued, will be assigned a new PHP based on the same auto-assignment algorithm used for new beneficiaries.

2. Beneficiaries who lose, then regain, Medicaid eligibility within a three-month period will be auto assigned to the beneficiaries' previous PHP unless the PHP is not offered in the region or the beneficiaries indicate in writing that they want to enroll in another PHP. If the PHP is not offered, the beneficiaries will be auto-assigned using the same auto-assignment algorithm for new beneficiaries.
3. Beneficiaries who have been disenrolled upon a Department-approved PHP request will be assigned to a new PHP using the same auto-assignment algorithm for new beneficiaries. The beneficiary cannot be reassigned to the PHP requesting disenrollment.

Whether beneficiaries are auto assigned, or choose a PHP but determines that the PHP does not meet their health care needs, the beneficiaries may disenroll/change their health plan based on the proposed rules described under "Disenrollment."

## Disenrollment

All managed care beneficiaries—whether they selected a PHP or were auto-assigned—will have a 90-day choice period following the PHP effective coverage date to switch PHPs without cause. This choice period, applicable at initial application and at annual redetermination, allows beneficiaries to re-assess their decision or assignment into a plan after experiencing the plan's provider network and clinical coverage policies. However, after the completion of the 90-day choice window, most beneficiaries must remain enrolled in their PHP for the remainder of their eligibility period, unless they can demonstrate cause for switching (e.g., moving out of PHP service area, or a complex medical condition is better served in different PHP). Certain special populations, for example, foster children, members of federally recognized tribes and individuals receiving LTSS in institutional and community based settings, will be able to switch PHPs at any time. All requests for disenrollment by the beneficiary or the PHP will be received by the enrollment broker. The Department will notify the beneficiary or authorized representative of the denial or approval of the "with cause" and "without cause" disenrollment requests.

### **"With Cause" Disenrollment**

Beneficiaries or their authorized representative may submit requests to the enrollment broker to switch plans "with cause" during the lock-in period for one of the following reasons, specified in federal law:

- Moving out of the PHP region.
- A PHP does not cover a service the beneficiary seeks because of the plan's moral or religious objection.
- Beneficiary needs concurrent, related services that are not all available within the PHP's network, and beneficiary's provider determines receiving services separately would subject the beneficiary to unnecessary risk.
- LTSS beneficiaries will be required to change their residential, institutional or employment-supports provider based on a change in status from in- to out-of-network.
- Beneficiary's complex medical conditions would be better served under different PHP. "Complex medical conditions" will be defined by the conditions that qualify for an expedited appeal.
- Family member becomes newly eligible or redetermined eligible and is enrolled in or chooses a different PHP than the beneficiary.
- Poor PHP performance, as determined by the Department after evaluation.

- “Other reasons,” including poor quality of care, lack of access to covered services or lack of access to providers experienced with meeting specific need as defined by the Department.

The enrollment broker will notify the Department of routine disenrollment decisions from beneficiaries within three calendar days of receipt. Beneficiaries will be notified no later than seven days from date of their request for a change.

### **“Without Cause” Disenrollment**

Beneficiaries can switch PHPs without cause during the initial 90 days following the effective date of new PHP enrollment. Children in foster care, children in adoptive placement and former foster children up to age 26, members of federally recognized tribes and individuals receiving LTSS in institutional and community-based settings may switch plans without cause at any time. The beneficiary will contact the enrollment Broker to make the requests for “without cause” disenrollment. The enrollment broker will approve or deny all complete “without cause” requests for disenrollment and communicate the decisions to the Department so that the Department can notify the individual within seven days.

### **PHP-initiated Disenrollment**

In rare occasions, PHPs may request disenrollment only if the beneficiary’s behavior seriously hinders the PHP’s ability to care for the beneficiary or other beneficiaries enrolled in the PHP, and the PHP has documented efforts to resolve issues with the beneficiary that forms the basis of the disenrollment request. PHPs will be prohibited from requesting beneficiary disenrollment because of an adverse change in the enrollee’s health status, enrollee’s utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the enrollee’s special needs.

The Department will review and decide on disenrollment requests from PHPs. The Department will receive, review, and approve or deny all complete clinically related “with cause” requests for disenrollment including concurrent related services, complex medical conditions, “other reasons,” and urgent medical needs.

### **Beneficiary Appeal of Disenrollment Determinations**

Beneficiaries may appeal adverse disenrollment determinations<sup>9</sup> made by the enrollment broker or the Department. The Department will send to the beneficiary, and/or the authorized representative, a Notice of Resolution for disenrollment requests that includes information regarding the beneficiary’s right to appeal any adverse disenrollment determination through a State Fair Hearing and instructions on how to appeal. Beneficiaries or their authorized representative, submit the appeal request form for a State Fair Hearing to the Office of Administrative Hearings (OAH) and the Department within 30 calendar days of the date on the Notice of Resolution. OAH will conduct disenrollment-related State Fair Hearings and issue final decisions.

### **Supporting an Informed Advanced Medical Home and Primary Care Provider (AMH/PCP) Selection**

The Department recognizes the importance of preserving beneficiary-provider relationships in the transition to Medicaid managed care. North Carolina will continue its focus on ensuring all beneficiaries will be served by an advanced medical home or primary care provider under Medicaid managed care and, therefore, will emphasize in the materials the importance of selecting a PHP in which the beneficiaries’ preferred providers are in-network. Beneficiaries will be able to use an online provider search tool operated by the enrollment broker that will be available when Medicaid managed care open enrollment begins, and will be able to receive

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<sup>9</sup> Adverse disenrollment determinations are defined as a determination by the Department or the enrollment broker to (i) deny a request made by an enrollee, or an authorized representative, to disenroll from a Prepaid Health Plan or (ii) approve a request made by a PHP to disenroll an enrollee from a Prepaid Health Plan. DHHS is seeking statutory authority to address adverse disenrollment determinations.

assistance in person or over the phone. This directory will be used to determine PHP-to-provider relationships to provide the most up-to-date information to support AMH/PCP selection during the eligibility application process in NC FAST.

### **Auto-Assignment of the AMH/PCP**

Beneficiaries who do not select an AMH/PCP during the plan selection or application period will be assigned to an AMH/PCP by the PHP in which they are enrolled. The criteria that PHPs will be required to use for this auto-assignment algorithm reflect the Department's long history of use of the medical home model and will favor AMH over non-AMH PCPs. Criteria that will be a part of the AMHs auto-assignment algorithm include family member assignment, geography, special medical needs, medical home status, and language/cultural preference.

### **Switching AMHs or PCPs**

To ensure beneficiaries are ultimately satisfied with their AMH/ PCP, the Department will build in additional protections and allowances for beneficiaries to change AMHs/ PCPs after enrollment into a PHP. Beneficiaries will have 30 days from the receipt of notification of their AMH/PCP assignment to change their AMH/ PCP without cause. Beneficiaries will also have 30 days to change their AMH or PCP without cause after their initial AMH/PCP visit, and up to one additional time every 12 months. Beneficiaries may change their AMH or PCP with cause at any time. Beneficiaries may contact the PHP to change AMHs or PCPs.

## **III. Beneficiary Supports in Managed Care**

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### **PHP Marketing**

PHP marketing activities can help publicize North Carolina's Medicaid managed care transition and educate potential enrollees about health plan options, but beneficiaries must be protected from coercive practices. The Department will permit PHPs to engage in specific types of marketing activities while establishing oversight mechanisms that protect beneficiaries from aggressive or misleading practices.

### **PHP Member Services**

After beneficiaries have selected or have been auto-assigned into a PHP, the PHPs will support their transition to managed care through dedicated member services departments. Once beneficiaries have selected and enrolled in a PHP, it will be crucial that they have continued access to information and assistance allowing beneficiaries to navigate their PHP, understand the benefits and services that are available to them, and maximize their access to appropriate care. The Department will require that PHPs operate a member services department that is accessible via a toll-free telephone line and adequately staffed with well-trained service representatives. Member services departments will explain how to access services, provide information on covered benefits, assist beneficiaries with making appointments, and perform a variety of other key functions including:

- Assisting with arranging non-emergency transportation for beneficiaries;
- Assisting beneficiaries in selecting or changing AMH/PCP;
- Fielding and responding to beneficiaries' questions and complaints;
- Clarifying information in the beneficiary handbook;

- Advising beneficiaries of the PHP's appeal and grievance program, the utilization review process, and beneficiary's right to a fair hearing, as applicable;
- Referring beneficiaries to the Department's enrollment broker if an individual requests information regarding how to enroll in or select a new PHP; and
- Referring beneficiaries to and, as applicable, working in partnership with the Department's ombudsman program to resolve enrollee issues.

These departments will be required to adequately respond to beneficiary needs in as close to real-time as possible. This includes providing access to live service representatives during regular business hours and periodic windows of extended business hours. PHPs must also ensure that telephone lines have the capability to handle calls from beneficiaries with Limited English Proficiency, as well as from beneficiaries with communications impairments (e.g., hearing and/or speech disabilities). Departments also will have the capacity to resolve emergency beneficiary issues on a 24-hour, 7-day-per week basis.

The Department will require PHPs to meet call center performance standards and regularly report performance on key metrics which the Department will use to ensure that enrollees receive high-quality customer service.

### Beneficiary Outreach and Education

Beneficiaries must be clearly and efficiently directed to the appropriate source for education, enrollment, and ombudsman services regardless of where the beneficiaries' search begins. Towards that end, the Department will develop a stakeholder engagement plan that will include information on outreach and education, beneficiary noticing and choice counseling. Entities with regular beneficiary contact which may include PHPs, local Departments of Social Services (DSS) offices, EBCI PHHS office(s), local health departments, LME-MCOs, beneficiary call centers and the Department's Medicaid website will be able to provide the direction to the appropriate sources. The Department will require the enrollment broker, ombudsman and PHPs to coordinate their outreach efforts to avoid confusion for beneficiaries.

### Health Promotion, Wellness and Disease Prevention

A high-performing Medicaid managed care system requires education for beneficiaries on health promotion and disease prevention. To assist in this effort, PHPs will develop health education and promotion programs that address prevention, wellness and early intervention of illness and disease that are offered at no charge to the beneficiary. To inform evaluation of the success of related initiatives, PHPs will regularly report to the Department on their enrollee health education and promotion program efforts and as applicable link such activities to quality outcomes.

### Beneficiary Feedback to PHPs and the Department

North Carolina's person-centered approach to managing individuals' health and well-being depends on feedback from beneficiaries—those who use Medicaid services—and their families. The Department is committed to ensuring beneficiaries can easily provide input on the quality of services received, ideas and suggestions to improve any aspect of Medicaid managed care, and to relay their level of overall satisfaction.

Options for communicating with the Department and PHPs will include providing feedback through PHP member services, enrollment broker call center and Department customer service center; public listening sessions and hearings; by participating in work groups, focus groups and advisory committees; joining

webinars and forums; in-person and online satisfaction surveys; and sending questions and recommendations using the Medicaid website, email or the U.S. Postal Service.

The Medicaid managed care ombudsman program will provide an independent resource to assist beneficiaries to ensure complaints are responded to and resolved promptly, and help navigate the formal appeals and grievances process, as described next.

## IV. Appeals and Grievances

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The Department is committed to helping beneficiaries enroll in PHPs that best meet their needs and resolve problems quickly with minimal burden.

The enrollment broker, PHP and ombudsman will be expected to comply with regulations related to Section 1557 of the Patient Protection and Affordable Care Act, the Americans with Disabilities Act and with 42 C.F.R. § Part 92, which prohibits discrimination based on race, color and national origin (including immigration status and English language proficiency).

Beneficiaries will be supported as needed by the ombudsman program in pursuing formal appeals related to adverse benefit determinations and adverse disenrollment determinations. Upon exhaustion of PHP processes for resolving adverse benefit determinations, beneficiaries will have the right to a State Fair Hearing.<sup>10</sup> Beneficiaries will be provided the opportunity to file a grievance with their PHP to express their dissatisfaction with any issue that does not relate to an adverse benefit determination (e.g., concerns regarding quality of care or behavior of a provider or PHP employee). The Department will establish an ombudsman program to support beneficiaries in these processes. PHPs will report on their appeal and grievance processes and outcomes, and the Department will monitor PHP performance to ensure compliance with related requirements.

### Beneficiary Appeals

As required by federal law, enrollees in Medicaid managed care will first seek to resolve appeals with their PHP and will have 60 days from the date of the notice of an adverse benefit determination to file a request for an appeal with the PHP. PHPs will be required to send written acknowledgement of the request within five calendar days for a standard appeal and within 24 hours for an expedited appeal request. To ensure access to services, enrollees may request that their benefits be continued or reinstated while the appeal is pending.

PHPs must provide written notice of resolution as expeditiously as the appellant's health condition requires and within 30 calendar days of receipt of a standard appeal request. For an expedited appeal request, PHPs must provide written notice of resolution, and make "reasonable effort" to provide oral notice within 72 hours of receipt of an appeal.

If the PHP upholds the adverse benefit determination, the enrollee may seek a State Fair Hearing at the Office of Administrative Hearings (OAH) after receiving the notice of resolution; the request must be made no later than 120 calendar days from the date of the notice. Mediation opportunities will be available to beneficiaries. Beneficiaries will have the right to request a continuation of benefits while the appeal is pending. OAH will also conduct disenrollment-related State Fair Hearings and issue final decisions.

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<sup>10</sup> In North Carolina, federally required "State Fair Hearings" are commonly referred to as "contested case hearings." See generally, Article 3 of Chapter 150B of the North Carolina General Statutes.

## Beneficiary Grievances

An enrollee may file a grievance with a PHP or enrollment broker at any time. These entities must acknowledge receipt of each grievance in writing within five calendar days and must resolve the grievance within 30 calendar days from the date the grievance is received. If a grievance relates to the denial of an expedited appeal request, PHPs must resolve the grievance and provide notice to all affected parties within five calendar days from the date the PHP receives the grievance.

## Ombudsman Program

North Carolina is committed to providing enrollees with support and assistance related to the appeals, grievance and fair hearing process, and to facilitating real-time issue resolution. The Department will develop an ombudsman program to aid Medicaid managed care and fee-for-service beneficiaries, especially during transition to managed care. The ombudsman program is anticipated to begin at a minimum of six months before the beginning of the managed care program. Key functions of the ombudsman program will include:

- **Education.** Provide education to individuals and communities regarding, for example, the managed care program and related topics, and provide referrals to other services as needed. This includes education on coverage, services, access, provisions and rights, and navigating the managed care system (particularly as new populations are phased in to managed care).
- **Advocacy.** Support beneficiaries in appeals, hearings, and grievances, and provide active assistance to beneficiaries that may include support during associated legal matters. The purpose is to mitigate challenges beneficiaries may face when denied a potentially covered benefit, participating in an appeal or fair hearing process by providing education on, and potentially assistance with, the hearing process. This advocacy may not include representation at a State fair hearing, but may refer the beneficiary to sources of legal representation.
- **Issue Resolution/Enrollee Assistance.** Serve as an advocate for resolving issues (e.g., related to eligibility, enrollment or access). This includes providing support to resolve issues before they are escalated. This assistance may include conducting investigations of PHPs based on beneficiary complaints if not appropriately resolved through PHP process, and referrals to other specialized assistance (e.g., other state programs, social support services).
- **Trend Monitoring.** Monitor trends in PHP performance and program issues, and bring these to the attention of the PHP, Department leadership or state policymakers.

The ombudsman program will be administered by an entity external to the Department. The Department will provide the ombudsman program staff with access to Departmental and other State IT systems, required information, and Department staff to facilitate its provision of effective advocacy and assistance to beneficiaries. The enrollment broker and PHPs will be required to work with the ombudsman to address beneficiary complaints about the managed care enrollment process and direct beneficiaries to their authorized representatives.