NC Medicaid's Move to Managed Care:
What Health Care Advocates Need to Know

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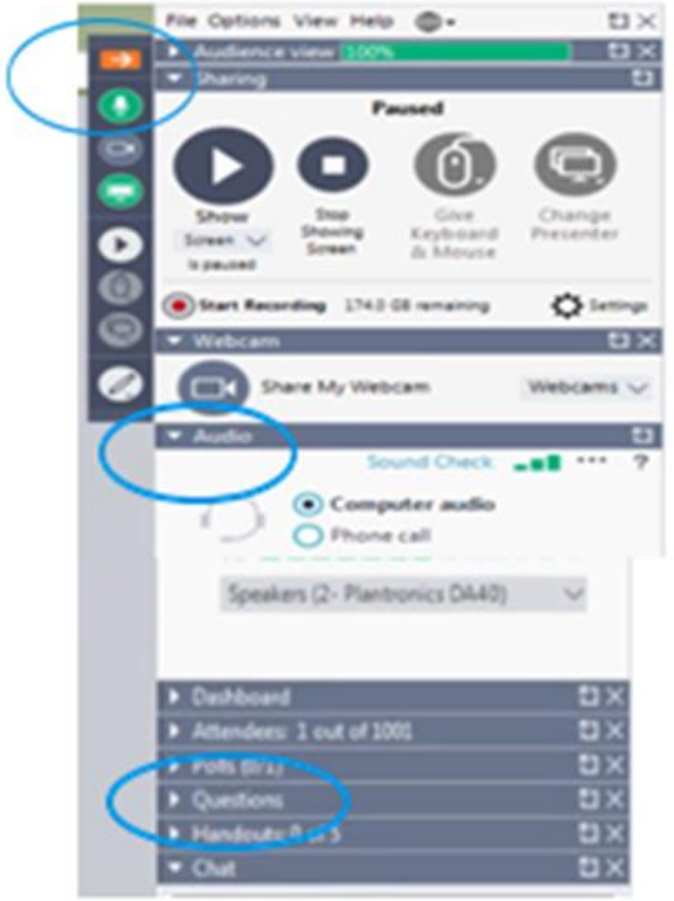

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Agenda

- Background
- Enrollment
- Services Changes
- Beneficiary Rights & Protections
- Issues to Watch
- How to Get Help for Beneficiaries
- Q&A

Background

Why the change and when is it happening?

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
  - Exception: Local Management Entities/Managed Care Organizations (LME/MCOs)

Existing Managed Care in NC

- Local Management Entity/Managed Care Organizations (LME/MCOs)
  - Quasi-governmental, regional entities
  - Contract with the NC Department of Health and Human Services (NC DHHS) to provide management of the public system of **mental health, developmental disabilities, and substance use disorder (MH/DD/SA) services, including Innovation waiver and "B3" services.**
  - Receive capitated payments and operate closed networks of providers
- Currently, there are 7 LME/MCOs operating within NC:
  - Alliance Health
  - Cardinal Innovations Healthcare
  - Eastpointe
  - Partners Behavioral Health Management
  - Sandhills Center
  - Vaya Health
  - Trillium Health Resources.

Transformation: 2015-2019

- 2015: NC General Assembly directed NC DHHS to change NC's current FFS Medicaid structure to one that relies on capitated managed care organizations (called Prepaid Health Plans or PHPs) to deliver care (Session Law 2015-245)
  - Changed how Medicaid is delivered, not who is eligible for the program
- 2016: DHHS submitted 1115 waiver to CMS in 2016
- 2017: Waiver amended by DHHS
- Nov 2018: Waiver approved by CMS
- Feb 2019: PHP Contracts awarded
- July 2019: Phased rollout planned to begin

Features of NC Medicaid Transformation

- Moving to “integrated care” model intended to be whole-person centered, addressing both medical and non-medical drivers of health
- Healthy Opportunities pilots to address social determinants of health
- Ombudsman program
- Provider support
- General changes under Medicaid Managed Care:
  - Different provider networks by plan
    - Standard Plans must accept any willing provider
    - Tailored Plans can have closed networks for behavioral health services
  - Appeal process
    - Mandatory plan level appeal
  - Choice of health plans (for most) and enrollment broker

What is NOT Changing Under Medicaid Transformation?

- Eligibility rules and process for Medicaid
- Covered Services (except for some new services being added)
- How services are authorized/delivered for exempt populations
- Waiver waitlists
- CHIP Eligibility (but CHIP beneficiaries must enroll unless exempt)

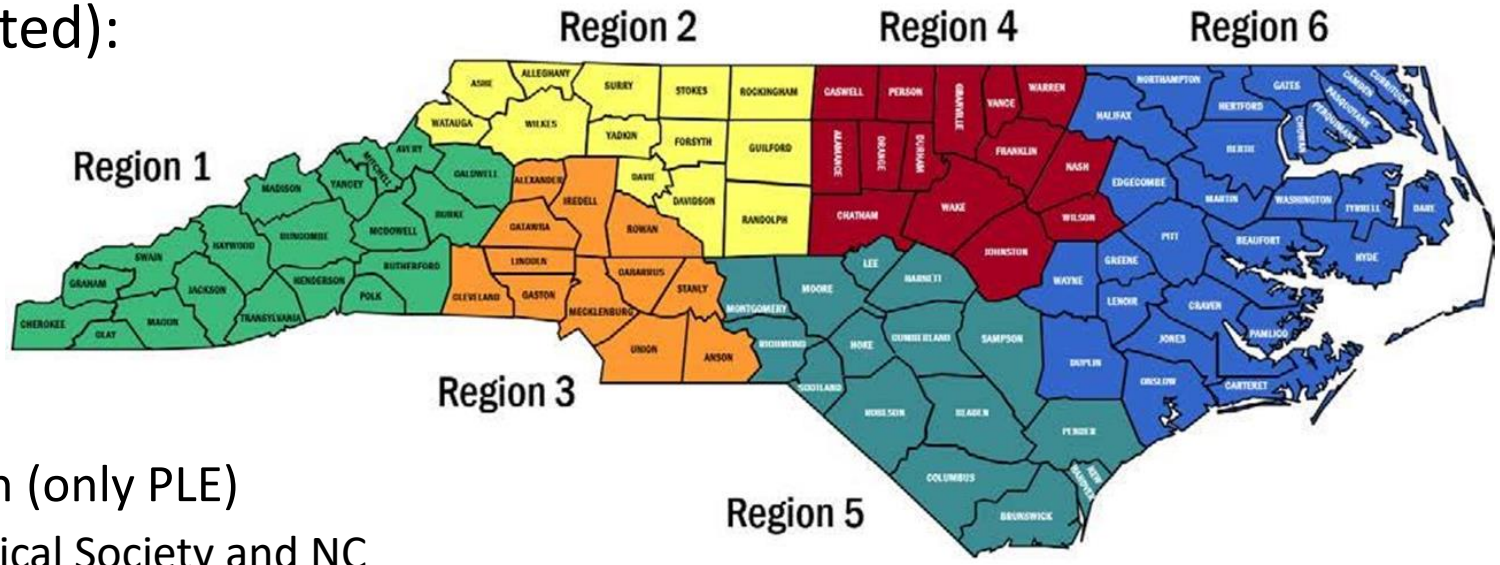
NC Medicaid Transformation Structure

- Legislation required NC DHHS to contract with four statewide Prepaid Health Plans (PHPs) and up to 12 regional PHPs to cover up to 6 regions. PHPs may be either:
  - Commercial plans (i.e. commercial HMOs) or Provider Led Entities (PLEs)* that are controlled by North Carolina providers for standard plans (see below)
  - LME/MCOs will serve as the PHP for the tailored plans (see below)
- Two types of health plans (Session Law 2018-48; CMS Medicaid waiver)
  - Standard plans—for most Medicaid enrollees, including those with mild-to-moderate behavioral health problems
  - Tailored plans—for people with serious mental health or substance use disorder needs, intellectual and developmental disabilities (IDD), or traumatic brain injury (TBI) (delayed launch until at least July 2021)

** PLEs are similar in concept to Accountable Care Organizations.* For PLEs a majority of voting members of the governing body must be NC physicians, PAs, NPs, or psychologists, at least 25% whom must have received Medicaid reimbursement sometime in last 24 months.

Standard Plans Selected by NC DHHS

- <u>Statewide</u> (no PLEs selected):
  - Blue Cross Blue Shield
  - AmeriHealth Caritas
  - United Health Care
  - WellCare
- <u>Regions 3 and 5</u>:
  - Carolina Complete Health (only PLE)
    - Partnership of NC Medical Society and NC Community Health Center Association, with Centene



Note: Appeals have been filed by three unsuccessful bidders. Requests to the judge to delay implementation are pending.

What Happens to LME/MCOs?

- Until July 2021:
  - LMEs continue managing care for MH/DD/SA but only for those with serious conditions (next slide).
  - Physical health care for this population continues to be Fee for Service
- 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

Two Types of Eligibility for Tailored Plans

(LME/FFS until July 2021)

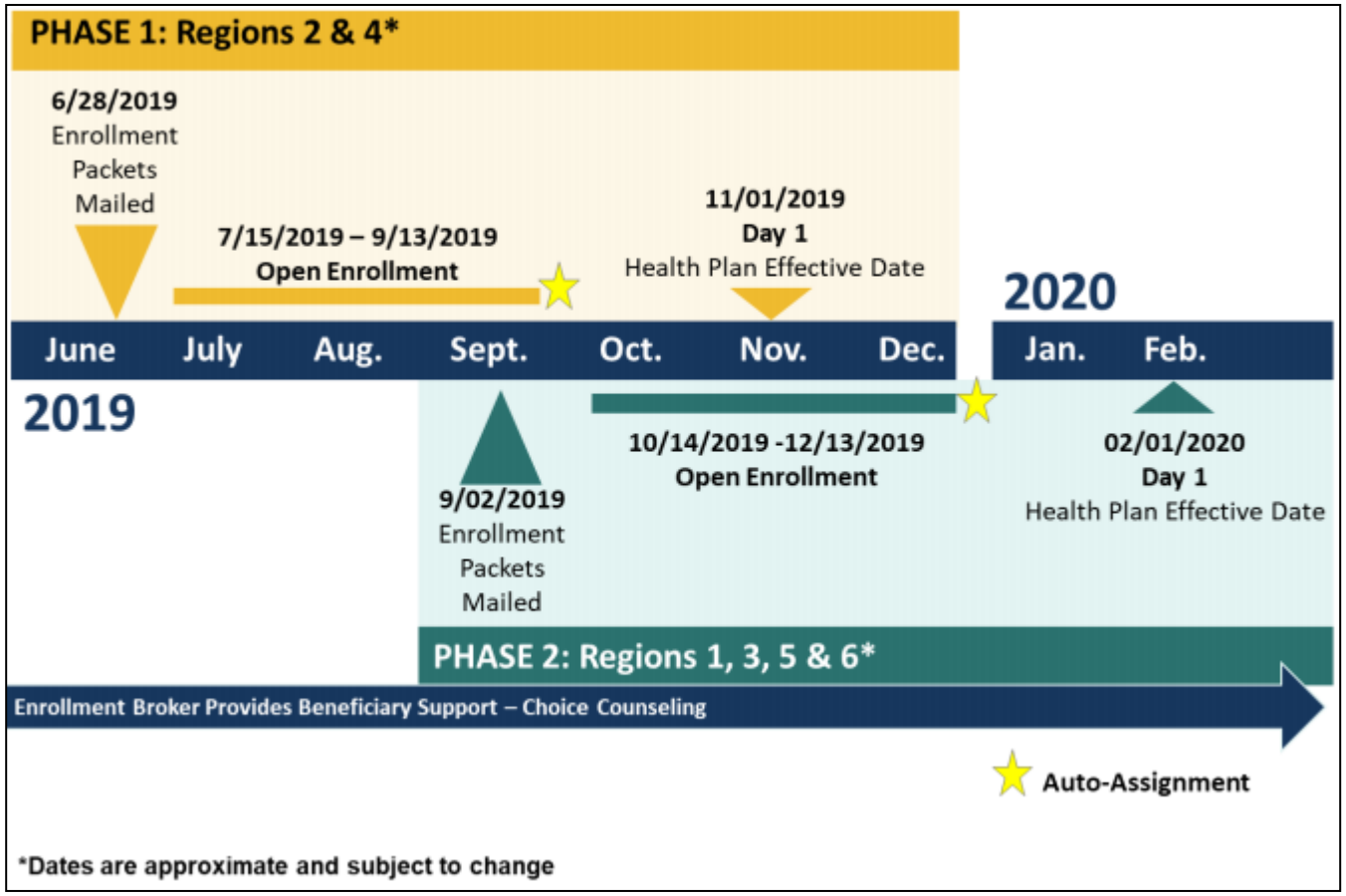
- **Diagnosis:** Includes individuals with:
  - serious emotional disturbance, or diagnosis of severe substance use disorder, or TBI; or
  - developmental disabilities, as defined in GS 122C-3(12a); or
  - serious MH, as defined by the 2012 settlement agreement with DOJ, including those in the Community Living Initiative settlement
- **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

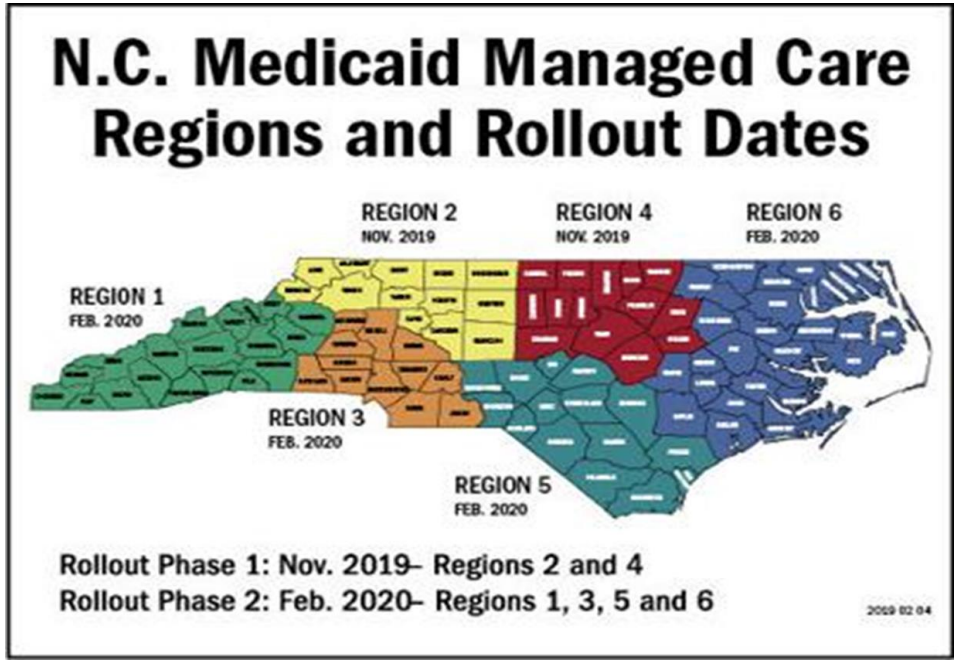
Details at https://files.nc.gov/ncdhhs/BH-IDD-TP-FinalPolicyGuidance-Final-20190318.pdf

Enrollment

Timeline, who is in/out, expected problems

Transition Timeline





Enrollment

- Individuals will be given a choice of plans
  - Independent enrollment broker (Maximus) to help Medicaid recipients select plan
  - 60 days to select a PHP and primary care physician (PCP). Those who do not select a PHP will be auto-assigned by Enrollment Broker based on specific criteria.
    - People have 90 days to change their PHP for any reason (eg, no cause).
    - Those who are exempt can disenroll at any time (because enrollment is voluntary)
  - Members can disenroll for cause at additional times in the year (RVP, Sec. VII, Attachment M)
- Choice of providers w/in the PHP: Each member will have a choice of Advanced Medical Home (AMH) or other PCP (RFP, Sec. V, Sec. VII Attachment M)
  - If member does not choose a medical home, will be auto assigned by the PHP.
  - Can change AMH/PCP without cause twice/year, and more often if for cause. Must contact PHP to change PCP.

Who Must Enroll & Who is Excluded or Delayed?

IN:

- Mandatory Enrollment: All Medicaid participants UNLESS they fit into an excluded category (~90%)
- Permissive Enrollment:
  - Eastern Band of Cherokee Indians
  - Beneficiaries with serious ID/DD or MH (until Tailored Plans begin)

Out (or *Delayed)

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

Problems with ID'ing Who Must Enroll

- State is relying on data matches to determine who must enroll.
  - State has no data on those new to Medicaid or new to NC.
  - State has limited data on other groups-e.g those age 0-3.
  - State's data may be out of date or incorrect.
- State will rely on beneficiaries not IDed by data match to "raise their hand" to self-ID as exempt from enrollment and then to request in writing that they be disenrolled from managed care. If request denied, right to appeal. State will rely on providers to help request exemption.
- Even for those state IDs as exempt, state may send confusing letters that encourage enrollment in managed care standard plans.
- Those with MH/DD/SA who are enrolled in standard plans may not be able to get the services they need until after they successfully disenroll.

What Do Affected Beneficiaries Need to Do?

Now:

Make sure Department of Social Services (DSS) has current mailing address, phone number, and email address so will receive all notices about this change.

Late June 2019 (or later):

*Look for a letter telling you to enroll in a health plan.

*Contact the enrollment broker to ask if you are exempt.

*If not exempt, ask enrollment broker to help choose plan/doctor.

Services Changes

Transportation, carve-outs, closed networks, provider payments

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 provide EPSDT and conduct outreach to children due EPSDT visit (Medicaid children <21 only)

Transportation now PHP responsibility. DSS retains responsibility for FFS 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, 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

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 providers 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 credentialing process

Care Management

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

- Medicaid enrollees will have access to care coordination and care management to address medical and nonmedical drivers of health care.
  - Local care management to be provided by Tier 3 advanced medical home (AMH) and from Local Health Departments
    - 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)

Healthy Opportunities Pilots

(regional pilots beginning in 2021)

- CMS gave NC DHHS authority to spend up to $650M over 5 years to support public-private regional pilots in 2-4 areas of the state through a competitive procurement process.
  - Expects to cover 25,000-50,000 people in the pilots
  - Standard plan PHPs will work with Lead Pilot Entities (LPEs) to manage pilot enrollees' care with services provided by local human services organizations, including community-based organizations and social services agencies
  - Scheduled to launch late 2019
- Aimed at creating the opportunities for people to be healthy by focusing on:
  - Housing, transportation, food, and/or interpersonal safety/toxic stress
- Pilots must target individuals with at least one health need (eg, chronic conditions, repeated use of ED) and one risk factor (eg, housing, food or transportation insecurity, or interpersonal violence)
- Pilots must show:
  - Increased integration across health and social services organizations,
  - Improved health care utilization and/or reduced costs for target population, and
  - Improved health outcomes for target population
  - Through rapid cycle assessments

CMS Waiver Approval. pp. 22-31; Healthy Opportunities Pilots Factsheet; Healthy Opportunities Pilots Policy Paper

Provider Payments (In-Network)

- Rate floors: DHHS will set rate floors (at FFS levels) for in-network physicians, physician extenders, hospitals and nursing facilities.
  - Floor for in-network PCPs, specialists, NPs, and PAs is 100% FFS (RFP, Sec. 11.4.1; Sec. V)
  - Nursing homes will be reimbursed no less than FFS rate in effect 6 months prior to state of capitation rating year
  - PHPs are required to pay an enhanced rate for vaginal deliveries (RFP Sec. 11.2, Sec. V)
- Hospitals: In initial years, PHPs will be required to pay hospitals a base rate (rate floor) that incorporate previous supplemental payments made to hospitals (outside of the claims payments) (Sec. 11.4.4, Sec. V)
  - Critical access hospitals and hospitals in economically depressed counties guaranteed FFS rate floor for 5 years, other hospitals for 3 years
  - The state will continue to pay hospitals for GME and DSH separately (~$225 million reduced from hospital capitation to allow for direct payments)

Provider Payments (In-Network)

- FQHCs/RHCs will receive FFS reimbursement levels, state will provide wrap-around payments (Sec. 11.4.3, Sec. V).
- PHPs required to pay pharmacists using the state's dispensing fee.
- Not clear how the state will assure that Local Health Departments or other safety net providers receive adequate reimbursement.
  - CMS rejected DHHS' attempt to require MCOs to pass through payments to safety net providers

Provider Payments (Out-of-Network)

- As general rule, PHP may pay out-of-network (OON) providers no more than 90% FFS rate if PHP made a good-faith effort to contract with provider, or provider excluded for failure to meet objective quality standards
- Exceptions:
  - Emergency and some post-stabilization services (until arrangements can be made to safety transfer patient to in-network facility) (100% Medicaid FFS rates)
  - Transition of care requirements (100% Medicaid FFS rates)
  - Out of state providers (if services are not reasonably available or member out of state and needs emergency/urgent care services and health would be endangered if care postponed until member returns to NC)
- PHP must hold member harmless (cannot impose higher out-of-pocket costs) for out-of-network care

Monitoring and Oversight

- PHPs must provide numerous reports to DHHS, including but not limited to:
  - Quality assurance, marketing activities, appeal and grievance requests and dispositions, strategies to promote clinical integration of behavioral health and physical health services, pharmacy drug utilization program, EPSDT reports, advance medical home, prevention and population health, network access, provider grievances and appeal, quality performance measures, and total cost of care pmpm. (RFP, Sec VII, Attachment J)
- PHPs must engage with different stakeholders, including federally recognized tribes, community and county organizations, other Departmental partners (eg, enrollment broker, DSS, Ombudsman)
- PHPs must have compliance plans; methods to prevent, detect and report fraud, waste and abuse (program integrity), and procedures to recover costs from parties with third party liability
- DHHS must contract for an independent evaluation (as part of the 1115 waiver)

Beneficiary Protections

Rights, due process, and common problems

Common Issues for Beneficiaries in Managed Care

- Confusion about process and who to contact
- Not being ID'd as exempt from managed care
- Inadequate assistance and information for choosing PHP and PCP
- Delays or inability to access Medicaid services because of:
  - Inadequate provider networks
  - Not continuing previously authorized services during transitions between plans or to FFS
  - Inaccurate/inadequate provider directories (eg not taking new Medicaid patients)
  - Improper denials of services including out of network care
  - Medicaid transportation denials
- Due process violations:
  - No notice or confusing notices about rights/services
  - Illegal discouragement of service/grievance/appeal requests
  - Untimely action on service/grievance/appeal requests
  - Services not continued or reinstated pending appeal

Most Important Points for Beneficiaries

- Choose health plan and doctor to provide healthcare, unless exempt.
  - Otherwise Medicaid will auto assign to a health plan and doctor.
- Liberal rules on changing plans or doctors
- Eligibility for Medicaid does not change.
- Medicaid will continue to cover the same services.
- Health plan will decide whether to approve services doctor requests.
- Generally must see “in network” providers.
- No enhanced MH/DD/SA services if in Standard Plan

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.

Appeal v. Grievance

- Appeal:
  - Review of adverse benefit determination
  - Request within 60 calendar days of notice
    - In writing or orally with follow up in writing (unless expedited)
    - Good cause exception
  - Internal appeal exhaustion mandatory
  - External medical review
  - Expedited Appeal

Appeal v. Grievance (cont.)

- Grievance:
  - Non-adverse benefit determination
  - Dissatisfaction with providers, treatment by MCO employees, etc.
- MCO must acknowledge receipt of each grievance and appeal
- Different people involved in decision v. grievance/appeal resolution

Due Process: Managed Care

Managed Care: Adverse Benefit Determination

1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2) The reduction, suspension, or termination of a previously authorized service.
3) The denial, in whole or in part, of payment for a service.
4) The failure to provide services in a timely manner, as defined by the State.
5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.
7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

42 C.F.R. § 438.400(b)

Continued Benefits—Managed Care

- The plan must continue benefits if:
  - Enrollee timely appeals
  - Appeal involves termination, suspension, or reduction of previously authorized service;
  - Service was ordered by an authorized provider;
  - The period covered by the original authorization has not expired; and
  - Enrollee files for continued benefits within 10 calendar days of the notice

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

Issues to Watch

Potential Enrollment Issues

- Is beneficiary exempt from enrolling in managed care? Required to enroll anyway? Told of right to disenroll?
- If beneficiary files request to disenroll from managed care, decision on request in writing with appeal rights?
- Was beneficiary subject to aggressive or misleading plan marketing practices or materials?
- Is plan's provider directory accurate? Are the providers listed accepting new patients?

Enrollment (cont.)

- Was beneficiary given choice of plans before auto enrollment in a plan?
- Was enrollment broker easily accessible and helpful to beneficiary in choosing a plan? In requesting exemption or to change plan?
- Was beneficiary permitted within 90 days after enrollment to change plans?
- Does beneficiary have good cause to change plans after 90 days? If so, did plan tell her this?
- Was request to change plans acted on? Decision in writing with appeal rights if denied?

Enrollment (cont.)

- If mental health condition worsened so that need for enhanced MH services, was beneficiary smoothly transitioned from standard plan to LME without interruption in care or delay in getting needed services?
- If beneficiary began receiving Medicare or started getting CAP-DA or CAP-C services, was she promptly disenrolled from managed care?
- Does plan disenroll or encourage to change plans its “high cost” patients or those who are “difficult”?
- If beneficiary changes plans or leaves managed care, do previously approved services continue without interruption? Was beneficiary allowed to keep same doctor/provider for at least 90 days?

Beneficiary Access to 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 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 diff sexual orientation)?

Access to Care

- Was beneficiary allowed to change primary care physician (PCP) without cause at least once per year?
- Does beneficiary need an Advanced Medical Home? If so, did plan provide one?
- Does plan assure that PCP provides quality care management to beneficiary?
- Does beneficiary 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?
- Did plan tell beneficiary about the right to out of network care?
- Was beneficiary denied out of network provider where plan cannot provide ready access to the same service through in network provider?
- Did plan tell client of right to free transportation to medical appointments if needed?
- If transportation was requested and denied, was denial in writing with appeal rights?

Access to Care

- Does plan cover all services required under state plan plus EPSDT services?
- Does plan meet mental health parity requirements in coverage policies and decisions?
- Does plan follow state definition of medical necessity?
- Does plan comply with EPSDT requirements for outreach, informing, screening, coverage decisions, and arranging for service for beneficiaries under age 21?

Denials of Care

- Does plan discourage requests for services or give misinformation?
- Does plan make decisions on requests for services in writing in a timely manner?
- Does plan comply with state clinical policies in making coverage decisions, instead of internal, unpublished guidelines?
- Does plan limit period of authorization of long term services and supports to an unreasonably short period of time, requiring reauthorization less than annually for chronic conditions?

Denials of Care

- Does plan 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 decision made?
- Does the written notice specify reason for decision and legal authority for same?
- Does the written notice make clear how much of which services approved and denied?
- Does written notice provide right to continued services pending appeal if termination or reduction before end of current authorization period?
- Is envelope notice came in postmarked the same day as date on the notice?

Denial of Care: Process

- If appeal was requested, was it timely processed by the plan?
- If beneficiary needed expedited appeal, was it granted?
- Did plan offer assistance in filing appeal or during appeal process?
- Did plan discourage appeal or continuing the appeal?
- Does plan allow appeals to be filed over the phone at first level of appeal?
- Does plan follow required process for expedited appeals?
- Does plan provide access to entire file free of charge during appeal?
- Does plan allow beneficiary to present case in person during first stage of appeal?
- Was first level of appeal decided by someone with appropriate credentials who is independent of persons who made initial decision?

Denial of Care: Process

- Was the first level appeal decision made within the required time frames?
- Is the first level appeal decision on the correct state form?
- Are all required enclosures included with that decision? Are they prepopulated?
- Does plan make entire beneficiary file available free of charge during OAH appeal?
- Did OAH expedite the appeal if warranted and requested?
- Did PHP continue or reinstate services pending appeal if required?

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!**

Questions or Concerns?

If beneficiaries have questions or problems, they should contact one of the following organizations for free legal advice/assistance:

Disability Rights NC (statewide for persons with disabilities) **1-877-235-4210** www.disabilityrightsnc.org

Legal Aid of NC (statewide except counties listed below) **1-866-219-LANC (5262)** www.legalaidnc.org

Pisgah Legal Services (Buncombe, Madison, Transylvania, Henderson, Polk and Rutherford County)) **1-800-489-6144** www.pisgahlegal.org

Charlotte Center for Legal Advocacy (Mecklenburg, Union, and Cabarrus County) **1-800-438-1254** www.charlottelegaladvocacy.org

For More Information

- Provider trainings from DHHS: https://medicaid.ncdhhs.gov/nc-medicaid-managed-care-training-courses
- CMS Waiver Approval https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/nc-medicaid-reform-ca.pdf
- Medicaid managed care Requests for Proposals (for PHPs) and related resources https://www.ncdhhs.gov/request-information
- Amended waiver (Nov. 20, 2017) https://files.nc.gov/ncdhhs/documents/files/NC-Amended1115DemonstrationWaiverApplication_GovCooperLtr_20171120.pdf?PpFJgK3wwi.BFkdX4t6e5L8oSXK6_c8B
- NC Medicaid Transformation Policy papers https://www.ncdhhs.gov/policy-papers
- Advanced Medical Home information https://medicaid.ncdhhs.gov/advanced-medical-home

Questions?