



Medicaid Managed Care
Proposed Concept Paper

North Carolina's Vision for Long-term Services and Supports under 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 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.

Input is welcome and appreciated. Send comments to Medicaid.Transformation@dhhs.nc.gov.

I. Introduction

The first priority of the North Carolina Department of Health and Human Services (the Department) is the health and well-being of the beneficiaries it serves. Medicaid beneficiaries who use long-term services and supports (LTSS) are among North Carolina's most vulnerable residents. The Department wants to ensure that this population experiences a seamless transition to Medicaid managed care and receives high-quality, accessible services within managed care.

Long-term Services and Supports (LTSS)

Medical and non-medical programs and services provided in a variety of settings, including, but not limited to, nursing facilities, other group or private living settings, and the community; to people of all ages for a short or extended time to support their regaining or maintaining maximum health and independence when living with a chronic illness or disability.

North Carolina is transitioning its Medicaid and NC Health Choice programs' care delivery system for most beneficiaries and services from a predominantly fee-for-service¹ to a predominantly managed care system.² Because of this transition, newly procured prepaid health plans (PHPs) will provide LTSS to enrollees currently receiving such services through Medicaid. The populations using LTSS are extremely diverse in terms of individuals' care needs, service utilization and spending. Managed care can offer significant opportunities to improve care coordination, access to community-based services and outcomes for these vulnerable populations, but requires special planning and preparation to ensure relationships with long-standing clinical and non-clinical providers will not be disrupted in the transition, that PHPs will be experienced in serving people with disabilities in a culturally competent manner, and that quality of care will be measured in a way that is meaningful to people who use LTSS.

The Department plans to enroll beneficiaries into managed care in phases, each of which will include some beneficiaries who use LTSS (see the appendix for managed care phase-in and enrollment). The three phases and the expected number of enrollees using LTSS in each phase are:³

- **Phase 1** (targeted for July 1, 2019): Approximately 14,500 Medicaid-only beneficiaries using State Plan LTSS will enroll in standard plans.
- **Phase 2:** Approximately 30,000 Medicaid beneficiaries using LTSS with serious mental illness (SMI), serious emotional disturbances (SED), substance use disorder (SUD), intellectual and developmental disabilities (I/DD), and traumatic brain injuries (TBI) will enroll in behavioral health and I/DD tailored plans (BH I/DD TPs).
- **Phase 3:** Remaining approximately 62,000 beneficiaries using LTSS will enroll in managed care.

This paper describes the PHP requirements designed to ensure that the unique needs of Medicaid-only beneficiaries who use LTSS will be met in year one of the transition to managed care. The concept paper lays out a roadmap for transitioning these individuals seamlessly into managed care on day one, with appropriate protections in place to ensure access to quality-driven, person-centered, community-based LTSS. This concept

¹ The Department currently has a managed care delivery system for behavioral health and I/DD 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.

² The Department is in discussions with the Eastern Band of Cherokee Indians Tribe (ECBI) on pathways to implementing a Tribal managed care option for Tribal enrollees who elect to participate in PHPs. The Tribal managed care option will be required to comply with all LTSS-specific requirements described in this concept paper for Tribal enrollees who use LTSS and choose to enroll in a PHP. The Tribal managed care option is subject to approval by the North Carolina General Assembly.

³ The phased approach for managed care implementation is subject to approval by the North Carolina General Assembly.

paper does not include details on the transition into managed care of populations that may use LTSS, but will enroll in managed care in later phases. The Department welcomes feedback from beneficiaries who use LTSS, families and stakeholders, and is committed to continuing to engage them in the continued design, implementation and monitoring of the program.⁴

II. Covered Benefits: Integrating LTSS with Physical and Behavioral Health Services

In the first year of managed care implementation, all PHPs will be required to cover all State Plan LTSS, including nursing facilities for up to 90 consecutive days, home health, personal care, hospice, home infusion therapy, private duty nursing and durable medical equipment.⁵ The Department envisions that competitively procured PHPs will provide and manage comprehensive physical health, behavioral health and LTSS for Medicaid-only enrollees under a single capitation rate.^{6,7} The proposed rate methodology will take into account different population groups' historical and expected service use and spending, and will include rate categories and risk adjustment to account for the costs of certain high-need PHP enrollees. This will protect a PHP that enrolls a disproportionate number of people who use LTSS or other high-need patients. The rate methodology also will not distinguish between institutional and community-based populations using LTSS to encourage PHPs to provide care in the most integrated and cost-efficient setting. Most LTSS will be excluded from any cost-sharing requirements as it is today, as the Department will require PHPs to impose the same cost-sharing requirements used in the Medicaid fee-for-service program.

III. Clinical Coverage Policies

North Carolina's clinical coverage policies define which beneficiaries are eligible for which services, including standards related to clinical eligibility for the service, benefit limits and prior authorization requirements. The Department will require PHPs to cover State Plan LTSS, except Program of All-inclusive Care for the Elderly (PACE) services, which are excluded from Medicaid managed care. Consistent with approaches in other states, PHPs will be required to use the Department's definition of "medical necessity" when making coverage determinations.⁸ PHPs also will be prohibited from setting benefit limits that are more stringent than in the current fee-for-service program, consistent with federal requirements. For example, North Carolina's fee-for-service program covers 100 home health aide visits per year per beneficiary; therefore, PHPs could cover 125 visits, but could not limit a beneficiary to only 75 visits.

For a limited number of services—none of which are LTSS—the Department will require PHPs to use existing Medicaid clinical coverage policies. Additional information on clinical coverage policies is included in the [Managed Care Benefits and Clinical Coverage Policies Concept Paper](#). The Department also will develop a

⁴ 42 CFR 438.70

⁵ The Department has proposed to exclude from managed care in Year 1 individuals in nursing facilities for longer than 90 days, as they are similar to the dually eligible population who will not initially enroll in managed care.

⁶ The Department outlined its comprehensive approach to setting capitation rates for PHP-covered services in Appendix A of the "Managed Care Program Actuarial" request for information, released Nov. 2, 2017. The rate-setting process was developed in a way that supports the objectives of the new managed care program to 1) advance high-value care, and 2) establish a sustainable program with predictable costs.

⁷ The Department has proposed integrating behavioral health services into managed care, subject to approval by the North Carolina General Assembly.

⁸ All medical services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants. 10A NCAC 25A .0201 (1990).

common prior authorization request form for use by all PHPs to standardize access to appropriate services for beneficiaries and to reduce administrative burden on providers. Finally, the Department will encourage PHPs to use “in-lieu-of services” (ILS), which are services or settings that are not covered under the State Plan but are a medically appropriate, cost-effective alternative to a service that is covered. One example is the use of physician home visits for high-risk, medically frail individuals as a substitute for in-office visits.

With respect to service authorizations, and as required by federal law, the Department will require PHPs to ensure all decisions that deny a service authorization request, or limit a service in amount, duration or scope that is less than requested, be made by a licensed provider who has the appropriate clinical expertise in treating the enrollee’s condition or disease. Although not required by federal law, North Carolina will require PHPs ensure that their provider support functions include an after-hours telephone service staffed by appropriate medical personnel, including access to a physician on call, a primary care physician or a member of a physician group able to authorize care. This requirement will ensure access to critical services, such as personal care services, and prevent a decline in health or functioning for individuals discharged from a hospital or nursing facility at night or on a weekend.

In addition, the Department will maintain strong oversight of PHP clinical coverage and utilization management policies. PHPs will be required to submit materials on their utilization management programs, including clinical coverage policies, to the Department for approval; PHPs will revise their policies based on changes requested by the Department. Per federal requirements, PHPs are prohibited from denying or reducing the amount, duration or scope of a required service because of the enrollee’s diagnosis, type of illness or condition.⁹

IV. Eligibility and Enrollment

The Department recognizes that current Medicaid enrollees, especially those using LTSS, will need a seamless transition from fee-for-service to Medicaid managed care at program launch, including continued access to preferred providers and health care.¹⁰ To that end, the Department will contract with an enrollment broker to facilitate the transition of Medicaid beneficiaries from fee-for-service to managed care, and to provide independent choice counseling to beneficiaries about their managed care options. The enrollment broker services will be complemented by a new, independent, managed care ombudsman program that will provide direct issue resolution assistance. Enrollment broker staff will receive training at least annually on the special needs of the North Carolina Medicaid population. This training will include awareness of and sensitivity to the health and health care needs of the LTSS population, including using communication devices and literacy support, and understanding the impact of certain social factors, such as substandard housing, food instability and lack of access to telephone or transportation services.

In addition, the Department will conduct outreach to current fee-for-service beneficiaries using LTSS who are transitioning into managed care, and will provide them with a 60-day plan selection period. Current enrollees who do not select a plan during this period will be automatically assigned a PHP based on an algorithm that prioritizes preserving existing provider relationships. These existing provider relationships will include the Medicaid beneficiary’s primary care provider or medical home that serves as the primary source of Medicaid

⁹ 42 CFR 438.210(a)(3)(ii)

¹⁰ Federal rules require that the Department provide beneficiaries with an opportunity to select a PHP and a support system to assist them in choosing a PHP that best meets their health care needs. 42 CFR 438.54. and 42 CFR 438.71

medical services for the beneficiary. New Medicaid applicants will be given an opportunity to select a PHP as part of the application process and will be auto-assigned into a PHP if no plan was selected.

All individuals, including enrollees who use LTSS, will have 90 days to change PHPs “without cause” (i.e., for any reason), following their initial enrollment in a PHP.¹¹ After the 90-day period, most enrollees will be required to remain enrolled in the PHP for the rest of the eligibility period unless certain “for cause” requirements are met.^{12,13} However, beneficiaries who use LTSS in institutional and community-based settings will be allowed to disenroll from their PHP and select a different PHP at any time.

V. Continued Services During Transitions of Care

The Department is committed to ensuring that beneficiaries who use LTSS do not experience disruptions in their care due to the transition to managed care or when transitioning from one PHP to another.¹⁴ Additionally, enrollees may encounter a situation where their provider no longer participates with the PHP in which they are enrolled and may be required to select a new provider. These transition points may jeopardize the enrollees’ ability to obtain necessary care, and place them at risk for hospitalization or institutionalization. To mitigate that risk, the Department will require a PHP to permit enrollees to continue to see their provider, including an LTSS provider, for up to 90 days when an enrollee transitions into a PHP, either from fee-for-service or another PHP, and is in an ongoing course of treatment, or has a significant medical condition and switching providers may disrupt the enrollee’s care.

Additionally, when a provider, including an LTSS provider, in good standing leaves a PHP’s network, the PHP must allow enrollees to continue seeing that provider for up to 90 days before safely transitioning them to a new network provider. The PHP must also actively assist members who are receiving LTSS in transitioning to another provider when their current LTSS provider has terminated participation. The Department will require the PHP to maintain the current set of services as approved in a plan of care for 90 days or until a new plan of care is put into place, whichever occurs first. As detailed in the grievances and appeals section, enrollees will be able to appeal adverse benefit determinations.

The Department has also proposed that beneficiaries using nursing facilities for 90 or more days will initially be excluded from managed care, as they are similar to dual eligible beneficiaries who will similarly not enroll in managed care at launch. However, some beneficiaries using LTSS may move in or out of managed care as their nursing facility stay extends beyond 90 days, or as they transition from a nursing facility into the community without obtaining a 1915(c) waiver slot. The Department has identified specific transitions of care protections to minimize disruptions in access to care for these populations. For beneficiaries who will move out of managed care due to the use of long-stay nursing facility services, PHPs will be required to notify the

¹¹ 42 CFR 438.56

¹² “For cause” disenrollment reasons include: Individuals who use LTSS can disenroll from their PHP if their continued enrollment would require them to change their residential, institutional or employment supports provider due to the fact that the provider is no longer participating with the PHP in which the individual is enrolled; enrollees’ complex medical conditions would be better served under a different PHP; enrollees’ need concurrent related services that are not all available within the PHP’s network and the provider determines receiving services separately would subject the enrollees to unnecessary risk; enrollees move out of the PHP’s service area; the PHP does not cover services due to moral or religious objections; enrollees require related services and such services cannot be provided within the network; a family member becomes newly eligible and is enrolled in a different PHP; poor performance of a PHP; and for “other reasons,” including poor quality of care, lack of access to covered services and lack of access to providers experienced with meeting a specific need, to be determined on a case-by-case basis.

¹³ Individuals who use LTSS in community and institutional settings, members of federally recognized tribes and children in foster care will be allowed to change plans at any time.

¹⁴ 42 CFR 438.62.

beneficiaries and their families of the transition, transfer enrollee medical and care management records, coordinate with the beneficiaries' case manager responsible for their care in the fee-for-service system, and otherwise undertake all reasonable efforts to ensure continued access to services for enrollees as this transition occurs. As noted above, for nursing facility residents who successfully transition into the community and are to become enrolled in managed care, the Department will require a PHP to permit enrollees to continue to see fee-for-service providers for up to 90 days to ensure continued access to services during this transition.

VI. Grievances and Appeals

North Carolina will ensure that Medicaid beneficiaries can resolve problems quickly and with minimal burden. North Carolina is committed to honoring and supporting the right of beneficiaries to pursue a formal appeal of an adverse benefit determination through their PHP or, upon exhaustion of the PHP appeal process, through timely access to a Department fair hearing. Consistent with federal requirements, beneficiaries who appeal adverse determinations prior to their effective date have the right to receive continued benefits at the previously authorized level pending the outcome of the final appeal determination.¹⁵

Beneficiaries also 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 require PHPs to report on their appeal and grievance processes and outcomes, and monitor plan performance to ensure compliance with related requirements and address any issues that may arise.

North Carolina will establish an independent ombudsman program that will complement the other forms of enrollee supports around managed care provided by the Enrollment Broker and PHP.¹⁶ The ombudsman will support and prepare enrollees on the appeals, grievance and fair hearing process, and facilitate real-time issue resolution. Consistent with federal rules, the Department will leverage the ombudsman to provide enhanced beneficiary support services for individuals who use LTSS.¹⁷ The ombudsman will be responsible for providing the additional support for those enrollees using LTSS, including:

- Serving as an access point for enrollee complaints and concerns,
- Providing education on enrollees' grievance and appeals rights within the PHP, the Department fair hearing process, enrollees' rights and responsibilities and additional resources available to enrollees outside of the managed care entity, and
- Assisting enrollees in navigating the eligibility, enrollment and benefits grievance and appeals processes, including referrals to legal representation.

The ombudsman also will work with existing LTSS information and referral sources in North Carolina, including but not limited to, area agencies on aging, aging and disability resource centers and independent living centers, to ensure that enrollees requiring LTSS receive the necessary supports. The ombudsman will regularly track and report monitoring metrics to the Department. These metrics will include data on the number of calls and complaints received from individuals using LTSS and how these complaints are resolved. As part of these

¹⁵ 42 CFR 438.420

¹⁶ This program is distinct from, but will collaborate with, the Department's [Long-Term Care Ombudsman Program](#), which assists residents of long term care facilities in exercising their rights and attempts to resolve grievances between residents, families and facilities.

¹⁷ 42 CFR 438.71

efforts, the ombudsman will provide guidance to the Department on identification, remediation and resolution of systemic issues relating to LTSS. The activities of the ombudsman will ensure that enrollees using LTSS are aware of their rights during the transition to managed care, and guarantee that any barriers to accessing care are quickly identified and remedied.

VII. Network Adequacy

The Department will ensure that PHPs maintain a network of providers sufficient to ensure access to all covered LTSS, and monitor and enforce compliance with network adequacy requirements.¹⁸ To accomplish this, the Department has developed network adequacy requirements that include specific standards for providers of LTSS. Each PHP will be required to contract with at least two providers of LTSS accepting new patients to deliver each State Plan LTSS in every county in the regions that it serves except for nursing facilities. For nursing facilities, each PHP will be required to ensure that it has contracted with at least one nursing facility accepting new residents in every county in the regions that it serves.

The Department will work to ensure that PHPs are complying with network adequacy requirements by mandating PHPs submit reports that summarize how their network complies with the Department's network adequacy standards, and by submitting their provider networks at least monthly and when there has been a "significant change" in the network. With the managed care ombudsman, the Department will review and monitor these reports, beneficiary satisfaction survey findings and beneficiary complaints regarding LTSS network access. These oversight efforts will ensure that all individuals requiring LTSS will be provided meaningful access to such services.

VIII. Care Management for People Who Use LTSS

The Department recognizes that individuals using LTSS have unique and sometimes challenging needs that are best supported by robust care management protocols. Standard plan PHPs will be required to assess members of identified "priority populations" for ongoing care management needs, in addition to general health need screenings, population health programs, transitional care management and care coordination for all enrollees. Enrollees with LTSS needs will be defined as one of the priority populations for care management, in line with federal requirements that managed care plans comprehensively assess all enrollees with LTSS needs and create person-centered care plans for this population.¹⁹ Additional information on care management is included in "[North Carolina's Care Management Strategy under Managed Care](#)" [concept paper](#). To ensure that this population receives the services it needs at the right time and place, the Department will require PHPs to comprehensively assess enrollees with LTSS needs to identify ongoing special conditions that require a course of treatment or regular care monitoring, develop person-centered care plans that will identify the services and supports enrollees need, and provide care management to ensure enrollees access needed services.

PHPs will be responsible for initially identifying individuals in need of LTSS using a claims data review, predictive modeling and an initial care needs screening. PHPs also may receive provider referrals and member self-referrals for care management, which the plan will validate with a comprehensive assessment. The Department plans to require that all PHPs use an assessment tool to comprehensively assess individuals requiring LTSS. The assessment will, at a minimum, evaluate an enrollee's:

¹⁸ 42 CFR 438.206; 42 CFR 438.66.

¹⁹ 42 CFR 438.208.

- Immediate care needs and current services,
- Use of other (non-Medicaid) state or local services,
- Health conditions,
- Physical, intellectual or developmental disabilities,
- Medications,
- Available informal, caregiver or social supports, including peer supports,
- Unmet health-related resource needs/social determinants of health (e.g., food, housing, transportation), and
- Current and past mental health and substance use disorders.

The Department will allow PHPs to use their own assessment tools and include additional content beyond the minimum requirements above. After managed care launch, the Department plans to develop a standard set of questions for future use. The Department will require that PHPs make best efforts to complete the comprehensive assessment within 30 days of identifying a new or existing enrollee who needs LTSS, and that the assessment take place in a location that meets the enrollee’s needs, including in the home “as appropriate.”

The comprehensive assessment will form the basis for development of a care plan for all enrollees with LTSS needs, and ongoing care management. PHPs must make best efforts to complete a care plan within 30 days of assessment and may not delay any needed services while care plans are being developed. In addition, enrollees with LTSS needs will be assigned a designated care manager to coordinate services, establish a multi-disciplinary care team for the enrollee, and perform medication reconciliation, referral follow-up, connections to peer supports, training on self-management and transitional care management as needed.

For enrollees who need LTSS, the care plan development and ongoing care management must be provided by a person with expertise in LTSS service coordination and trained in person-centered planning processes. As such, PHPs will be required to hire care managers who meet a minimum set of standards, or contract with an organization that has the relevant experience. LTSS care managers will be required to have, at a minimum, a bachelor’s degree in social work or a related human services field; two years of prior LTSS or home- and community-based service care coordination and management experience; and prior experience in a related discipline such as social work, geriatrics or pediatrics. PHPs also will be required to train LTSS care management staff in various LTSS care delivery and care management principles, such as person-centered needs assessments and care plan development, transitional care management, cultural competency, independent living, and motivational interviewing or comparable training. The Department will establish and require PHPs to adhere to minimum care manager-to-enrollee ratios for enrollees who use LTSS, in addition to the broader requirement that the majority of care management for all high-need enrollees be conducted at a local level.

PHPs will be required to reassess enrollee needs and review and revise (as necessary) each care plan at least every 12 months, when the enrollee’s circumstances or needs change significantly, or at the request of the enrollee. For example, a change in enrollee circumstances or needs could include an increased need for care, decreased need for care, transition into or out of an institution, or loss of a family/friend caretaker.

A robust care management program includes efforts to ensure enrollees receive and maintain care in the setting most appropriate to their needs. As part of the initial care needs screening and the comprehensive needs assessment, the Department will require PHPs to evaluate enrollee’s unmet health-related resource

needs/social determinants of health. Where unmet needs are identified, PHPs must have policies and procedures in place to address these needs through several strategies, including having a comprehensive understanding of the local community-based resources and having a housing specialist on staff or on contract who can assist individuals in securing housing. This feature will benefit enrollees with LTSS needs who are at-risk of losing their housing or who have unstable housing arrangements that could adversely impact their health status and functioning, and could help avoid or delay a nursing facility admission.

The Department also will require PHPs to have a transitional care management program to arrange and deploy community-based LTSS for enrollees transitioning from nursing facilities to the community. Accordingly, PHPs will be required to provide transitional care management that includes outreach to the enrollee's prior care managers, the enrollee's PCP and all other medical providers. Transitional care management must include, at a minimum, facilitating clinical handoffs, obtaining a copy of the discharge plan/summary, ensuring that a follow-up outpatient visit is scheduled ideally before discharge, conducting medication reconciliation, ensuring a care manager is assigned to manage the transition, and follow-up by the assigned care manager within 48 business hours of discharge. The housing specialist on staff at the PHP will ensure that beneficiaries using LTSS transitioning from nursing facilities to the community are connected to appropriate housing options as needed.

IX. Quality Measures and Performance

Federal regulations require that the Department establish and implement a managed care quality strategy that assesses and aims to improve the quality of services provided by PHPs, and further requires that the Department ensure PHPs themselves develop a quality assessment and performance improvement program.^{20,21} According to these requirements and in recognition of the Department's quality priorities, the Department has developed a [Medicaid Managed Care Quality Strategy](#) that sets a clear direction for the Department's aims, goals and objectives, and the standards and mechanisms that will be used to hold PHPs accountable for advancing them. This quality strategy is accompanied by a [PHP Quality Performance and Accountability](#) concept paper articulating the Department's pathway for advancing PHPs' accountability for quality outcomes over time.

While the quality standards and mechanisms developed for PHPs generally will apply to enrolled populations with LTSS needs, the Department has taken the additional step of including specific quality objectives and measures for populations with LTSS needs. PHPs will be required to report specific quality measures for the LTSS population related to individual health and functioning, to health promotion and prevention.²² The Department will use these measures, among others, to further refine its objectives over time, and—most importantly—to continually advance PHP performance expectations. These performance expectations will be tied not only to a PHP's overall performance, but the Department will assess opportunities to improve disparities in quality of care, including those based on the enrollee's disability status.²³

PHPs also are expected to develop Quality Assessment and Performance Improvement programs, which must be annually reviewed and approved by the Department, and contain mechanisms to address health care

²⁰ 42 CFR 438.340.

²¹ 42 CFR 438.330.

²² LTSS-specific quality measures may include LTSS populations with a health risk assessment completed within 90 days of enrollment; and participants in the Demonstration who remained stable or improved in ADL functioning between previous assessment and most recent assessment.

²³ For these purposes, "disability status" is defined as whether the individual qualified for Medicaid based on a disability.

disparities, and assess the quality and appropriateness of care to enrollees with LTSS needs. Specifically, PHPs must include assessment of care during transitions between care settings and a comparison of services and supports received with those set forth in the enrollee's care plan. Further, as a part of these programs, PHPs are required to develop and obtain Department approval for performance improvement projects that are aligned to the quality strategy.

X. Cultural Competency

Federal statute and regulations require that managed care organizations promote the delivery of services in a culturally competent manner to all enrollees, including those with disabilities.²⁴ Federal law also requires PHPs to “ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.”²⁵ To meet the requirements set forth in federal laws and regulations, the Department will require PHPs to comply with the Americans with Disabilities Act (ADA), and ensure that its representatives and network providers support people with disabilities, including individuals who are blind, deaf or hard of hearing, and adhere to accessibility standards for oral and written communications. PHPs will be required to designate a Disability Coordinator to oversee the PHP and network providers' compliance with federal and state laws and regulations pertaining to persons with disabilities, including requiring network providers ensure physical access, communication access, accommodations, and accessible equipment for enrollees with physical or mental disabilities.

Additionally, the Department will require that PHPs provide trainings for network providers and PHP staff that interact with enrollees (e.g., member services staff) to increase awareness of and sensitivity to the needs of individuals with disabilities. This training must include topics such as sensitivity and awareness to the needs of people with disabilities, use of communication devices by people with disabilities, ADA compliance, independent living philosophies, overcoming barriers to accessing medical care, and understanding the impact certain social factors, such as substandard housing, poor diet and lack of access to telephone or transportation, have on enrollees' health and health care needs. This will ensure that those requiring LTSS are treated with respect by PHP staff and providers, and are provided supports and services targeted to the specific health needs of these individuals. The ombudsman will serve as a locus for enrollee concerns or complaints related to ADA compliance or accessibility standards.

XI. LTSS Member Advisory Committee

PHPs are federally required to create a member advisory committee when LTSS are covered through managed care.²⁶ The Department values the input of individuals who use LTSS and believes that the views and real-life experience of these individuals and their families must be heard to ensure their needs are being met. To that end, the Department will require that all PHPs create a member advisory committee, which will be tasked with providing stakeholder input and advice regarding the LTSS covered under the PHP contract. At a minimum, the committee must be comprised of enrollees accessing LTSS, representatives of enrollees receiving LTSS, LTSS providers and the PHP staff involved in the authorization of LTSS and/or care management for LTSS users. The Member Advisory committee must meet at least quarterly.

²⁴ See Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency, 68 Fed. Reg. 103 (May 29, 2003); 42 U.S.C. Sect. 18001; 42 CFR 206; 45 C.F.R. 92.

²⁵ 42 CFR 438.206(c)(3).

²⁶ 42 CFR 438.110.

Appendix: Estimated Comprehensive Managed Care Enrollment by Cohort Based on NC DHHS Proposed Phase in Schedule

| Population Cohort with Proposed Timing for Comprehensive Managed Care Enrollment | Beneficiaries Based on SFY 2016 Historical Enrollment | | |
|--|---|---|--|
| | Estimated Average Beneficiaries by Group | Estimated Average Beneficiaries by Cohort | Cohort as Percent of Total Beneficiaries |
| Year 1: Standard Plan - Aged, Blind, Disabled | 140,000 | 1,525,000 | 73% |
| Year 1: Standard Plan - All Other | 1,385,000 | | |
| Year 3: Tailored Plan - Non-Duals | 85,000 | 135,000 | 6% |
| Year 3: Tailored Plan - Duals | 27,000 | | |
| Year 3: Foster Children | 23,000 | | |
| Year 5: Non-Dual LTSS | 5,000 | 217,000 | 10% |
| Year 5: Full Duals (Non-TP) | 212,000 | | |
| Excluded: Family Planning | 103,000 | 208,000 | 10% |
| Excluded: Medically Needy | 23,000 | | |
| Excluded: Other | 82,000 | | |
| Total | 2,085,000 | 2,085,000 | 100% |

Source

Exhibit prepared Feb. 8, 2018, by the NC DHHS Division of Health Benefits, based on ["Population Profiles,"](#) released Nov. 9, 2017.

Notes

- Estimates are based on SFY 2016 historical experience and do not include projected enrollment growth.
- Timing for managed care enrollment is proposed and subject to change.
- Tailored plan population estimates are subject to change based on legislation and data availability.
- "Non-dual LTSS" includes CAP/C, CAP/DA and individuals with a nursing facility stay of 90 days or more.
- "Excluded: Other" is primarily comprised of partial dual eligible enrollees.
- See source documentation for calculation methodology, assumptions and limitations.