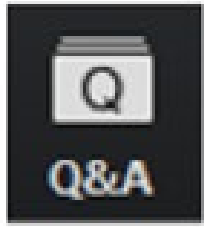
Back Porch Chat: Medicaid Managed Care Hot Topics

September 16, 2021

RCC (Relay Conference Captioning)
Participants can access real-time captioning for this webinar here: https://www.captionedtext.com/client/event.aspx?EventID=4906881&CustomerID=324

Logistics for today's COVID-19 Forum

Question during the live webinar



Technical assistance

technicalassistanceCOVID19@gmail.com

AGENDA

01 Quick Hot Topics

02 BH/IDD Tailored Plan Program Overview

03 Tailored Care Management

04 Request to Move to NC Medicaid Direct

05 Q&A

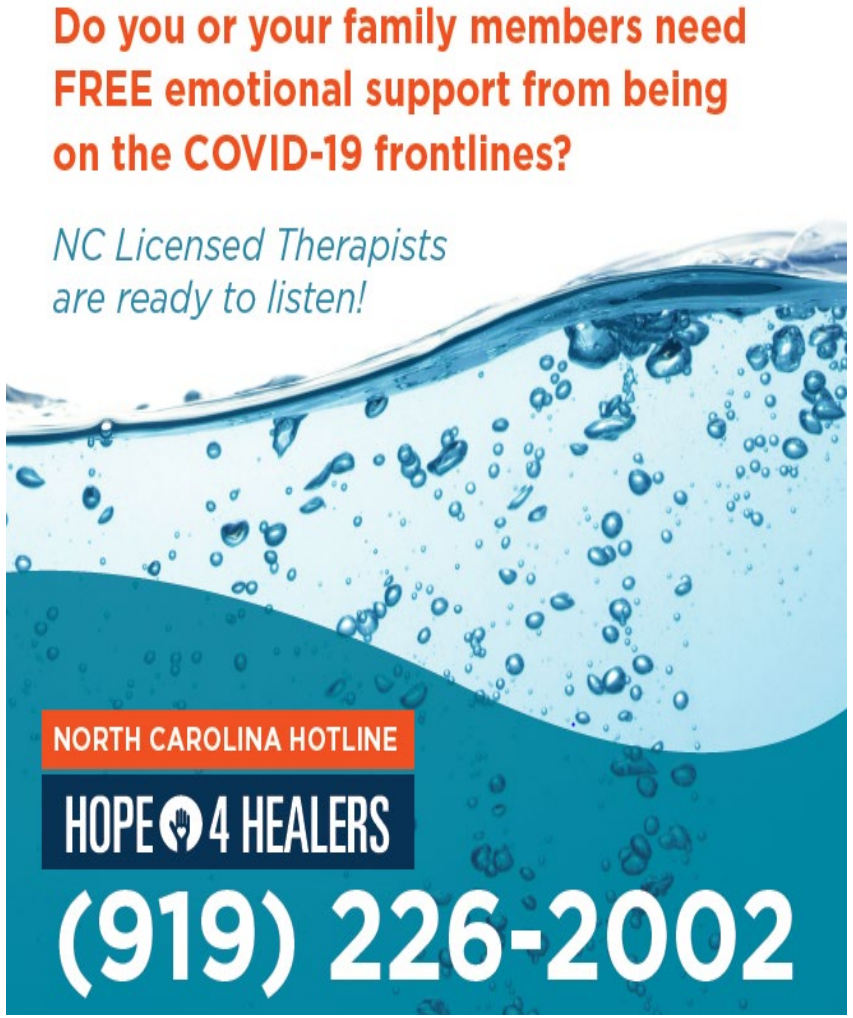
Supporting North Carolina's Healthcare Team

Hope4Healers Helpline

NC Psychological Foundation partnership

Provides mental health and resilience supports for healthcare, childcare and other workers on the frontlines of the COVID-19 response

Available 24/7 and staffed by licensed mental health professionals for follow-up



Provider Playbook Updates

The Provider Playbook is a collection of information and tools specifically designed to assist providers transitioning to NC Medicaid Managed Care. New resources added to the fact sheet page include:

- **Managed Care Claims and Prior Authorizations Submission - Part 2 (Updated)** – An overview of frequently asked questions regarding providers and PHPs during the claims and prior authorization submission process.
- **What Providers Need to Know After Managed Care Launch (Updated)** – An overview of key dates, reminders and links to assist providers and their beneficiaries after Managed Care launch on July 1, 2021.

Provider Prior Authorizations

If a prior authorization (PA) was previously obtained by your practice for Medicaid members prior to managed care go-live on July 1, 2021, the PA has been sent from the State to your health plan and no further action is needed.

Health plans are receiving PA requests that were previously submitted and approved by NC Medicaid. Please do **NOT** submit a PA if one was already approved by the State. If a practice wants to verify a health plan has received a PA, please contact the health plan provider relations team directly at:

- **AmeriHealth Caritas: Provider Services:** 888-738-0004
- **Carolina Complete: Provider Services**: 833-552-3876
- **Healthy Blue: Provider Services:** 844-594-5072
- **United Healthcare: Provider Services**: 800-638-3302
- **WellCare:** Provider Services: 866-799-5318

For more information about PAs, see the Managed Care Claims and Prior Authorization Submission fact sheets under Programs and Services.

Interim Process for Submitting Prior Authorization Requests for Beneficiaries Disenrolled to NC Medicaid Direct

In its Aug. 4, 2021, Medicaid bulletin, Prior Authorizations Covered When a Beneficiary Transitions to NC Medicaid Direct, the Department outlined its intended long-term design to transfer most **Standard Plan prior authorizations (PA)** to NC Medicaid Direct for impacted beneficiaries. Providers are encouraged to review this Bulletin to confirm which PA types are included in this long-term design.

A Medicaid beneficiary enrolled in a Standard Plan Prepaid Health Plan (PHP) may be later identified as a member of a Medicaid population that is exempt or excluded from Standard Plan enrollment. This will **result in a beneficiary's disenrollment** from the PHP and return to NC Medicaid Direct.

A PHP may be currently waiving PA requirements for some or all its covered services. If a PHP member is moved back to NC Medicaid Direct, the beneficiary may not have a PA transferred for a service that requires an authorization in NC Medicaid Direct. **The absence of a PA may result in service disruption upon a beneficiary's return to NC Medicaid Direct.**

To ensure beneficiaries and providers do not experience service disruption in the scenario previously outlined, a provider **may be required to submit a prior authorization request to the applicable NC Medicaid Direct vendor** in order to continue services to the beneficiary. To support providers through this process, the Department will allow retroactive review of prior authorization requests for beneficiaries who have been moved back to NC Medicaid Direct from a Standard Plan.

For more information, please refer to the Medicaid bulletin Interim Process for Submitting Prior Authorization Requests for Beneficiaries Disenrolled to NC Medicaid Direct.

Claims Denied – Taxonomy Codes Missing, Incorrect, or Inactive

More than two months after NC Medicaid Managed Care launch, PHPs continue to see the billing issue of professional and institutional EDI claims (ASC X12 837-P and ASC X12 837-I) with missing or invalid (non-taxonomy values or non-enrolled taxonomy codes) billing provider, rendering provider, and/or attending provider taxonomy codes.

Taxonomy codes must be included when submitting claims to prepaid health plans (PHPs), whether the claim comes from the individual provider or through a clearinghouse. Submission of claims with missing or incorrect taxonomy codes will cause the claims to deny and delay provider payments.

For more information **including a list of the specific denial codes providers receive** for missing/invalid taxonomy codes from each PHP, please see Medicaid bulletin article Claims Denied – Taxonomy Codes Missing, Incorrect, or Inactive

Survey Question

Where is your office in submitting claims with valid taxonomies?

A. No issues - claims are not currently denying for taxonomy issues

B. Our claims have denied for missing/invalid taxonomy data, but we understand the problem and are working on correcting our billing

C. Claims are still denying for missing/invalid taxonomy data, and we are working with our EDI vendor or clearinghouse to understand why

D. Claims are denying for missing/invalid taxonomy data, and I have no idea why

E. Claims are denying but I don’t know why, and I don’t know if it is related to taxonomy billing problems

Survey Question

What have you found helpful in solving your taxonomy billing issues? (check all that apply)

A. DHHS/PHP bulletins

B. Claim denial reason descriptions

C. Working with PHPs for claim billing support

D. Sharing DHHS or PHP provided guidance with my EDI vendor

E. Sharing DHHS or PHP provided guidance with my clearinghouse

F. Other

G. Nothing

Standard Plan Claims Current State

What Is Going Well

- The total weekly payment to providers for pharmacy and medical claims is like pre-MCL payments
- More pharmacy claims are getting paid, and fewer are getting denied in managed care

What We Are Tracking Closely

- Institutional and professional claims are denying at a higher rate since managed care launch, with missing or invalid taxonomy billing issues contributing to the denials
- PHPs continue to work with providers to address billing and system issues to support individual provider payments

Prepaid Health Plan Interest and Penalties for Provider Claims

In accordance with Section V. H.1.d of the NC PHP Contract, prepaid health plans (PHPs) are required to pay interest and penalties to providers if the PHP fails to accurately pay or inappropriately denies a clean claim within 30 calendar days of receipt of medical claims or within 14 calendar days of receipt for pharmacy claims.

- This includes incorrect denials, and under- or partial-payments that are identified and paid on reprocessed claims.
- It is the PHP's responsibility to issue interest and penalty payments to providers when applicable.

A clean claim is a claim for services submitted to a PHP by an NC Medicaid Managed Care medical or pharmacy service provider which can be processed without obtaining additional information from the submitter in order to adjudicate the claim.

If the PHP fails to implement fee schedule changes and reprocess impacted claims with the correct rates within 45 calendar days of notification of a fee schedule change from NC Medicaid, the PHP must pay interest and penalties on the adjusted amount.

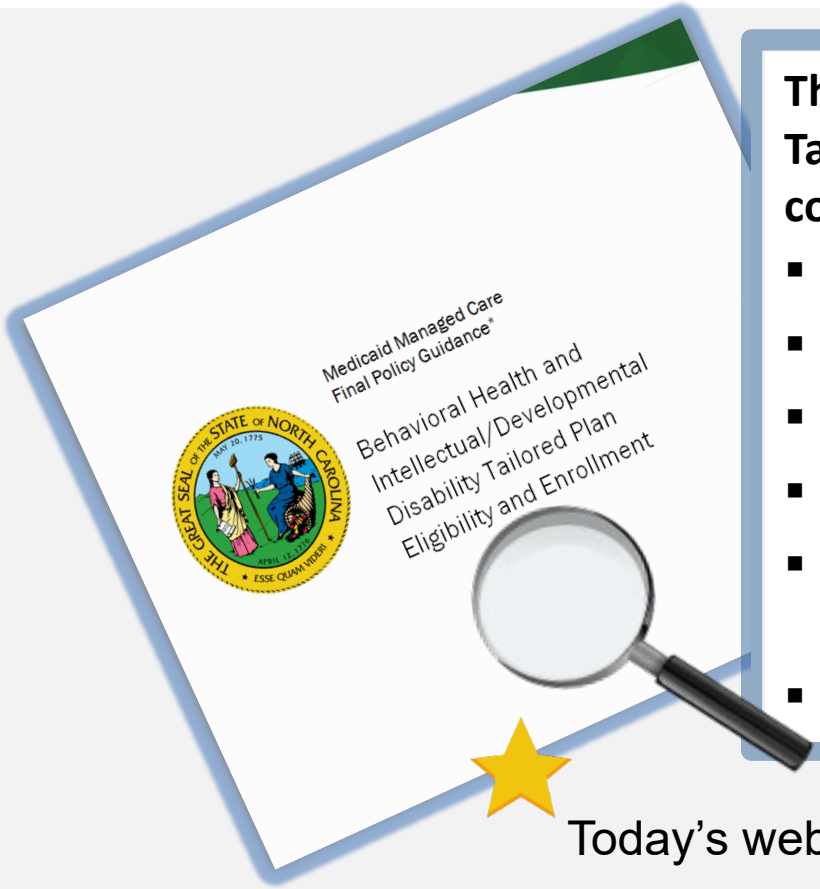
For more information, please see Medicaid bulletin Prepaid Health Plan Interest and Penalties for Provider Claims.

COVID Vaccinations

- Please continue to encourage COVID vaccination in ALL patient encounters, including care management
- ***Data on vaccines for Medicaid members will soon be available in NCIR for PHPs to download and providers to query.***
- PHPs are developing COVID vaccination member incentive programs (stay tuned for more information on a future Back Porch Chat)

BH I/DD Tailored Plan E&E Paper

In July 2019, North Carolina's Department of Health and Human Services released the Behavioral Health and Intellectual/Developmental Disability (BH I/DD) Tailored Plan Eligibility and Enrollment (E&E) Final Policy Guidance.



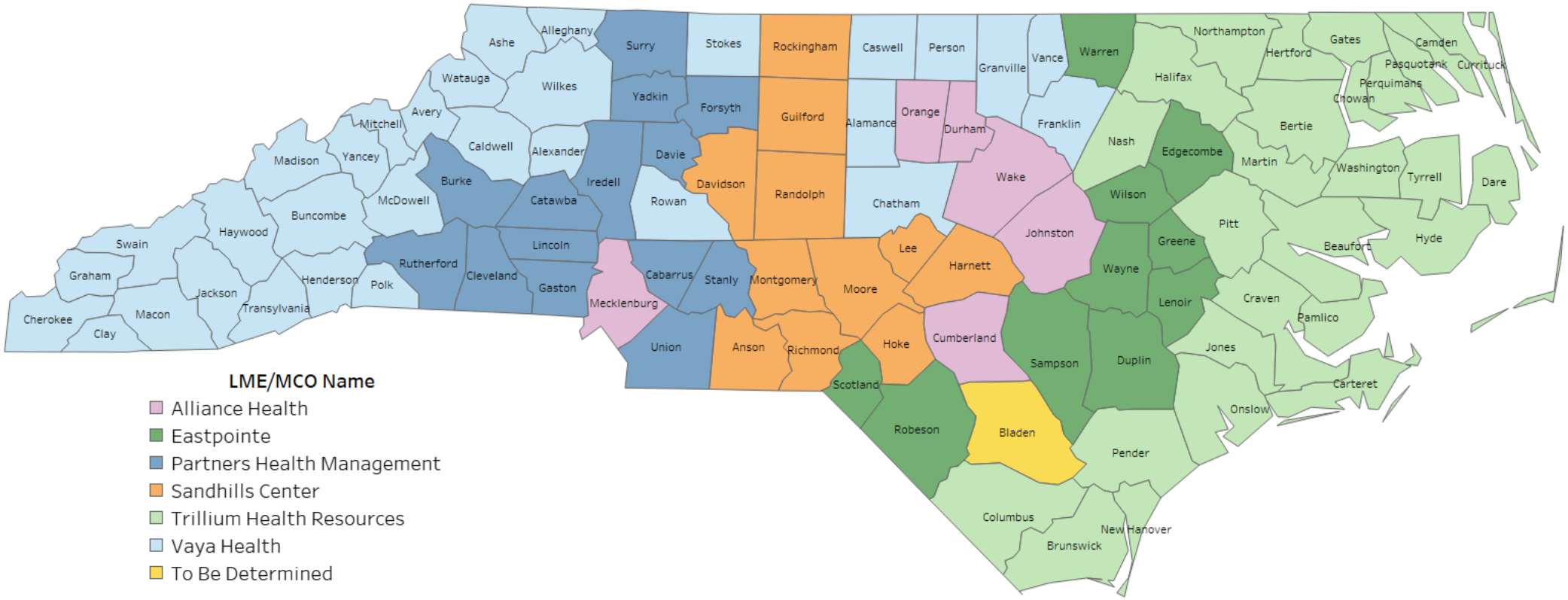
The paper provides an overview of the BH I/DD Tailored Plan E&E processes developed to date, covering topics including:

- Guiding principles
- Medicaid managed care eligibility
- BH I/DD Tailored Plan eligibility criteria
- Process for enrolling in a BH I/DD Tailored Plan
- Transitions between Standard Plans and BH I/DD Tailored Plans
- Benefits covered in BH I/DD Tailored Plans

Today's webinar reviews key concepts in the paper. The full paper can be found here.

Tailored Plan

Regional Behavioral Health and Intellectual/Developmental Disability Tailored Plans - Projected County Alignments at Tailored Plan Launch for July 1, 2022



Note: This map shows projected county assignments based on disengagements requested or approved as of 9/2/21. County realignment and disengagement requests must go through the process identified in law and rule which ultimately require approval by the DHHS Secretary.

Overview of BH I/DD Tailored Plan Eligibility

Certain beneficiaries with more intensive behavioral health needs (including mental health and substance use), I/DDs, and TBI will be eligible to enroll in a BH I/DD Tailored Plan. DHHS is conducting regular data reviews to identify eligible beneficiaries.

BH I/DD Tailored Plan Eligibility Criteria Identified via Data Reviews

- Enrolled in the Innovations Waiver or wait list; TBI Waiver
- Enrolled in the Transition to Community Living Initiative (TCLI)
- Have used a Medicaid service that will only be available through a BH I/DD Tailored Plan
- Have used a behavioral health, I/DD, or TBI service funded with state, local, federal or other non-Medicaid funds
- Children with complex needs, as defined in the 2016 settlement agreement
- Have a qualifying I/DD diagnosis code
- Meet qualifying SMI, SED, or SUD criteria based on diagnosis and/or service use
- Have had an admission to a state psychiatric hospital or alcohol and drug abuse treatment center (ADATC), including, but not limited to, individuals who have had one or more involuntary treatment episodes in a State-owned facility
- Have had two or more visits to the emergency department for a psychiatric problem; two or more psychiatric hospitalizations or readmissions; or two or more episodes using behavioral health crisis services within 18 months

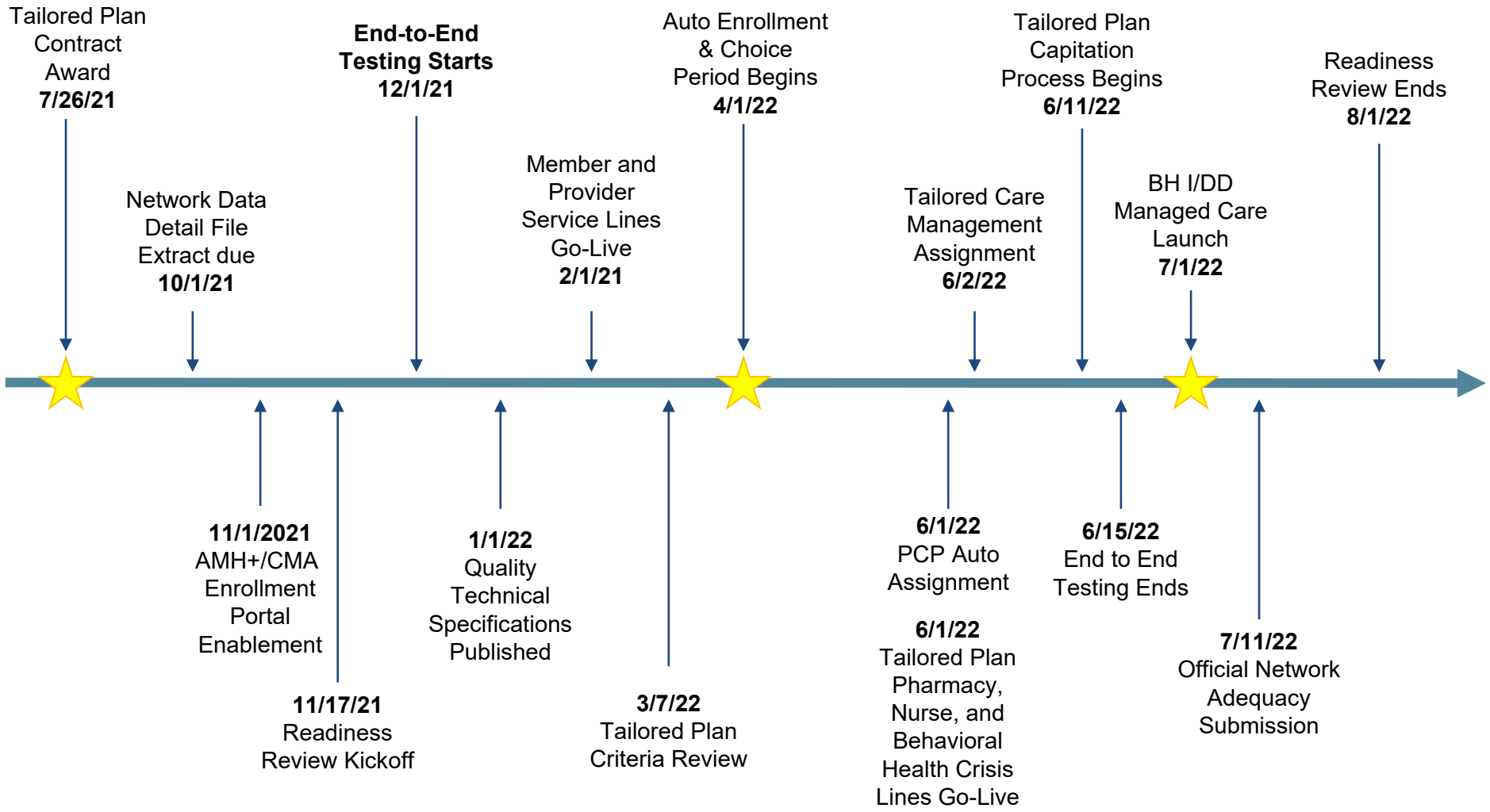
Comparing Plan BH/IDD/TBI Benefits

Available In Both SPs and BH I/DD Tailored Plans	Available Only in BH I/DD TPs (or LME-MCOs Prior To Launch)
State Plan Services • Inpatient behavioral health services • Outpatient behavioral health emergency room services • Outpatient behavioral health services provided by direct-enrolled providers • Psychological services in health departments and school-based health centers sponsored by health departments • Peer supports • Research-based intensive BH treatment for Autism Spectrum Disorder • Diagnostic assessment • EPSDT • *Partial hospitalization* • *Mobile crisis management* • *Facility-based crisis services for children and adolescents* • *Professional treatment services in facility-based crisis program* • *Outpatient opioid treatment* • *Ambulatory detoxification* • *Non-hospital medical detoxification* • *Medically supervised detoxification crisis stabilization*	**State Plan Services** • Residential treatment facility services • Intermediate care facilities for individuals with intellectual disabilities (ICF/IID) • *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)* • *Psychosocial rehabilitation* • *Substance abuse non-medical community residential treatment* • *Substance abuse medically monitored residential treatment* • *Substance abuse intensive outpatient program (SAIOP)* • *Substance abuse comprehensive outpatient treatment program (SACOT)* **Waiver Services** • Innovations waiver services • TBI waiver services • 1915(b)(3) services **State-Funded behavioral health, I/DD and TBI Services**

Enhanced Behavioral Health Services are Italicized

TP Key Milestone Timeline

THE TAILORED PLAN HAS AN EXPEDITIED TIMELINE AND LEVERAGES PROCESSES FROM THE STANDARD PLAN IMPLEMENTATION.



Transition to Whole-Person Care Management Under Tailored Plans

Tailored Care Management is the primary care management model for Tailored Plans and reflects the Department's broader goal for whole-person care under one Medicaid managed care plan.

Current State	Future State: Tailored Plans
LME-MCOs coordinate BH, I/DD and TBI services **CCNC coordinates physical health services** *LME-MCO care coordination is only available to a subset of the population served by LME-MCOs* 	**Tailored Plans will provide whole-person care management** *Tailored Care Management will be available to all enrollees unless they are obtaining duplicative services* 

Three Approaches to Delivering Tailored Care Management

Department of Health and Human Services

Establishes care management standards for BH I/DD Tailored Plans aligning with federal Health Home requirements.

The BH I/DD Tailored Plan will act as the Health Home and will be responsible for meeting federal Health Home requirements

BH I/DD Tailored Plan (Health Home)

Approach 1:
"AMH+" Primary Care Practice
Practices must be certified by the Department to provide Tailored Care Management.

Approach 2:
Care Management Agency (CMA)
Organizations eligible for certification by the Department as CMAs include those that provide BH or I/DD services.

Approach 3:
BH I/DD Tailored Plan-Based Care Manager

The Department will allow – but not require – AMH+ practices and CMAs to work with a **CIN or other partner** to assist with the requirements of the Tailored Care Management model, within the Department's guidelines.

Primary Care and Tailored Care Management

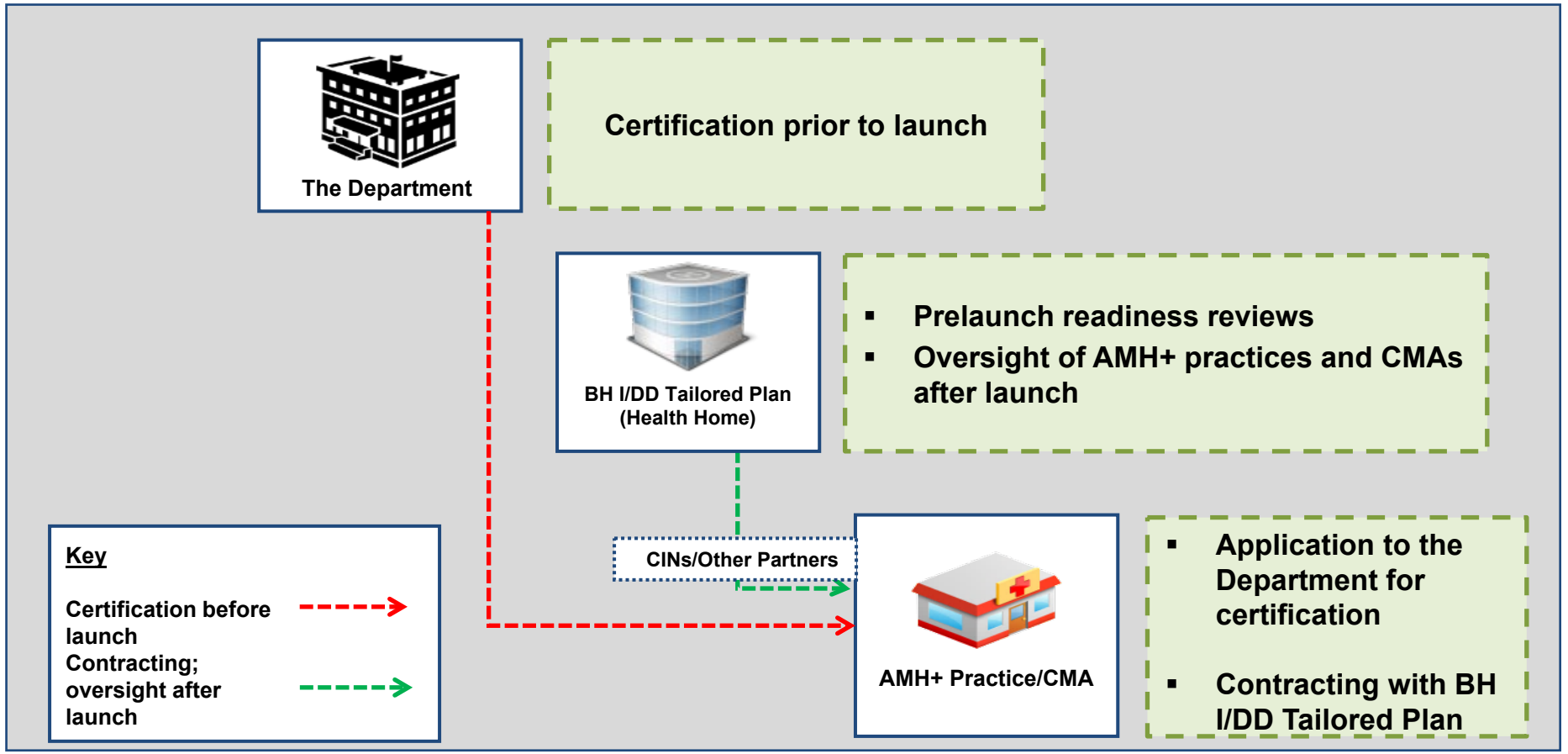
All Tailored Plan members will have both a Primary Care Provider (PCP) and a Tailored Care Management provider (AMH+, CMA, or TP-based care manager).

- Members will be assigned to
  - a PCP for general primary care services and then
  - an AMH+, CMA, or plan-based care manager for the purpose of receiving Tailored Care Management

- **If a member's PCP is certified as an AMH+, the member may also be assigned to that practice for Tailored Care Management.**
  - However, the member may instead be assigned to a CMA or plan-based care manger, depending on member choice and best assignment fit to meet the members care management needs.

Overview: Certification and Oversight

Providers must be certified as an AMH+ practice or CMA to perform Tailored Care Management.



AMH+ and CMA Certification Process

For the period prior to BH I/DD Tailored Plan launch, DHHS will facilitate desk reviews and site visits to determine whether a provider organization should be certified to perform Tailored Care Management.

DHHS Role: DHHS has responsibility for stages 1-3, culminating in a certification decision for each application.

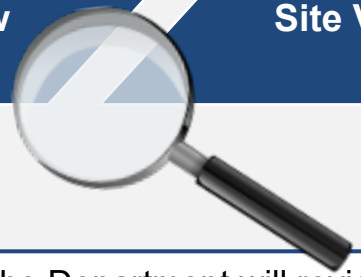
BH I/DD Tailored Plan Role (LME-MCO): Oversight transitions to plan level.

STAGE 1 Provider Application

STAGE 2 Desk Review

STAGE 3 Site Visits

STAGE 4 Readiness Review/ Contracting

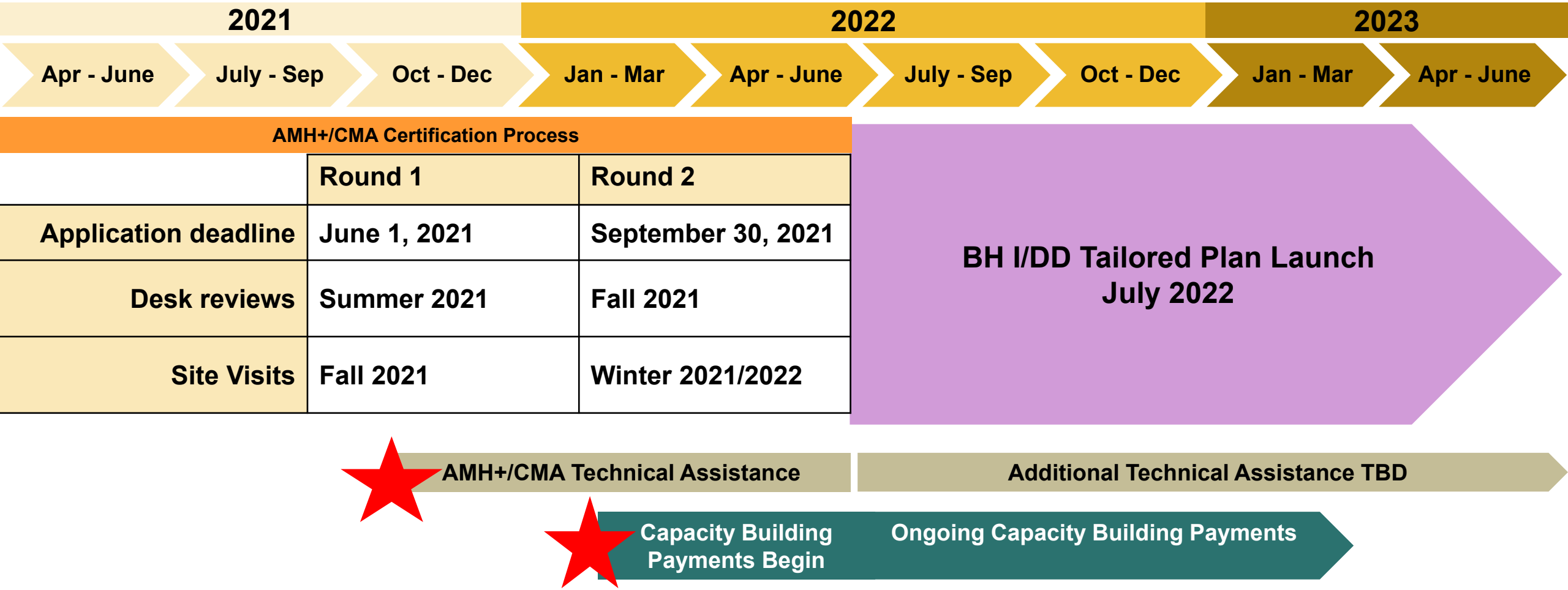


The AMH+ and CMA certification process is separate from the Medicaid enrollment process.

Desk Review: The Department will review each written application to determine whether the organization has the potential to satisfy the full criteria at BH I/DD Tailored Plan launch.

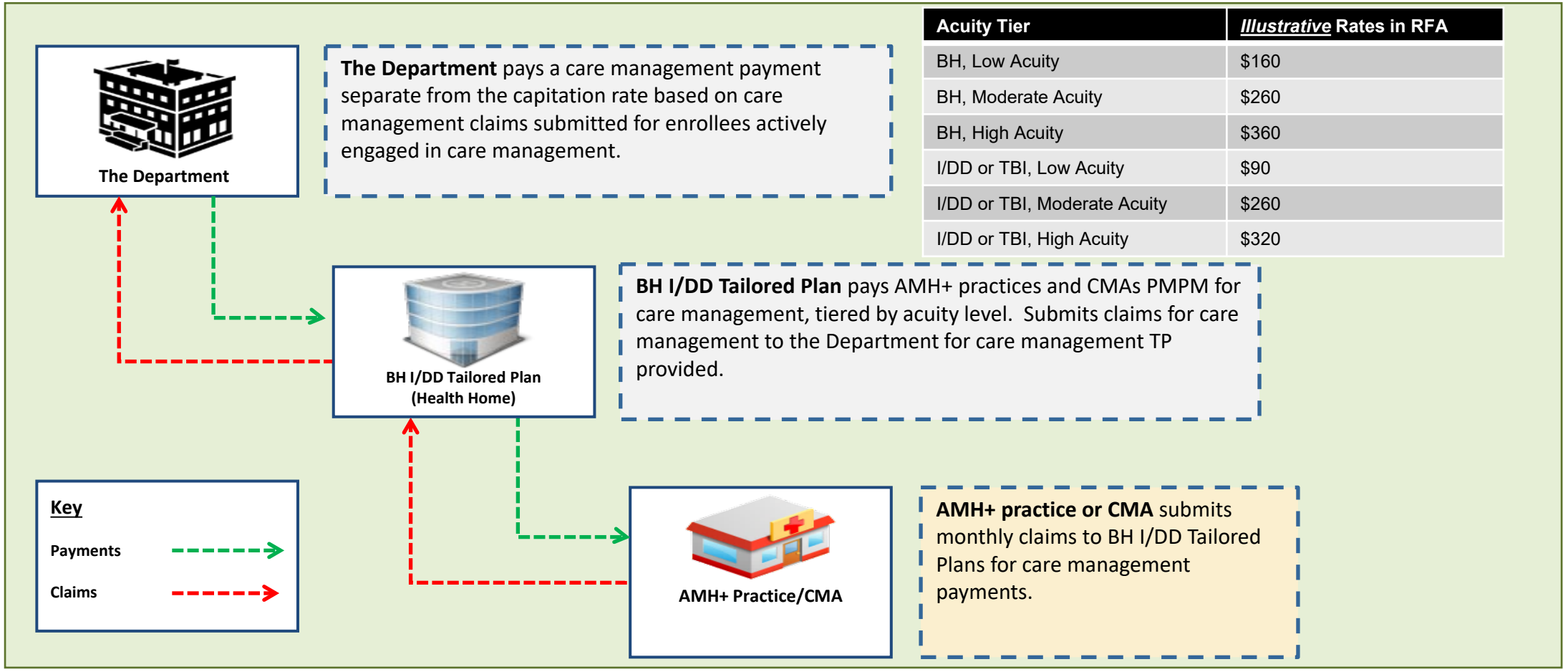
Site Visit: The Department will arrange to conduct one or more site visits with providers that "pass" the desk review to drive a final decision on certification, and to increase understanding of each organization's capacity, strengths, and areas for improvement, including need for capacity building funding.

Timeline for Tailored Care Management Activities



Payment for Care Management

AMH+ practices and CMAs will be paid standardized (fixed) monthly rate, tiered by acuity for members who receive a TCM encounter.



Acuity Tier	*Illustrative* Rates in RFA
BH, Low Acuity	$160
BH, Moderate Acuity	$260
BH, High Acuity	$360
I/DD or TBI, Low Acuity	$90
I/DD or TBI, Moderate Acuity	$260
I/DD or TBI, High Acuity	$320

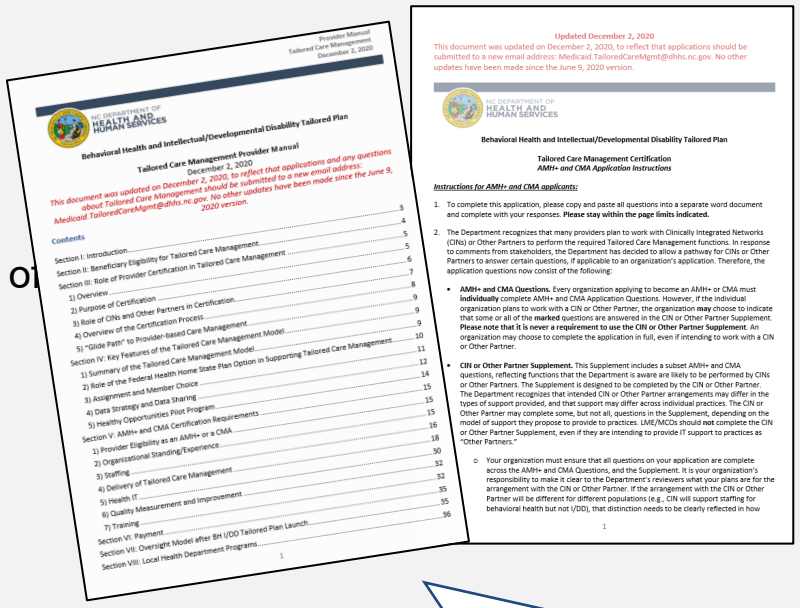
Certification Requirements Overview

The AMH+ and CMA certification application will assess whether organizations are credibly on track to deliver Tailored Care Management by BH I/DD Tailored Plan launch.

Requirements:

1. Meet **eligibility definitions** as an AMH+ or CMA
2. Show appropriate **organizational standing/experience**
3. Show appropriate **staffing**
4. Demonstrate the ability to deliver all **required elements** of the Tailored Care Management model
5. Meet **health IT** requirements
6. Meet **quality measurement and improvement** requirements
7. Participate in **required training** (occurs after initial certification)

- Organizations do not have to be fully ready now, but must be able to describe their plans to achieve readiness.
- **The Department intends to provide "capacity building" funding for provider organizations. More detail on this opportunity will be forthcoming.**



Behavioral Health and Intellectual/Developmental Disability Tailored Plan

Tailored Care Management Provider Manual

December 2, 2020

Contents

Tailored Care Management Certification

AMH+ and CMA Application Instructions

Organizations should cross-reference the Tailored Care Management Provider Manual when completing the Application Form.

Eligibility

Advanced Medical Home Plus (AMH+)

- **Definition:** Primary care practices **actively serving as AMH Tier 3 practices**, whose providers have experience delivering primary care services to the BH I/DD Tailored Plan eligible population or can otherwise demonstrate strong competency to serve that population. To demonstrate experience and competency to serve the BH I/DD Tailored Plan eligible population, **each AMH+ applicant must attest that it has a patient panel with at least 100 active Medicaid patients who have an SMI, SED, or severe SUD; an I/DD; or a TBI**.
- **AMH+ practices may, but are not required to, offer integrated primary care and behavioral health or I/DD services.**
- To be eligible to become an AMH+, the practice must **intend to become a network primary care provider for BH I/DD Tailored Plans**.

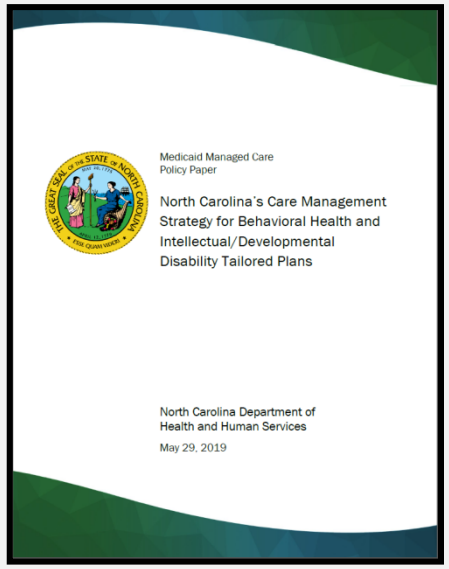
Care Management Agency (CMA)

- **Definition:** Provider organizations with **experience delivering behavioral health, I/DD, and/or TBI services to the BH I/DD Tailored Plan eligible population**, that will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model.
- To be eligible to become a CMA, an organization's **primary purpose** at the time of certification must be the delivery of NC Medicaid, NC Health Choice, or State-funded services, other than care management, to the BH I/DD Tailored Plan eligible population in North Carolina. The "CMA" designation is new and will be unique to providers serving the BH I/DD Tailored Plan population.

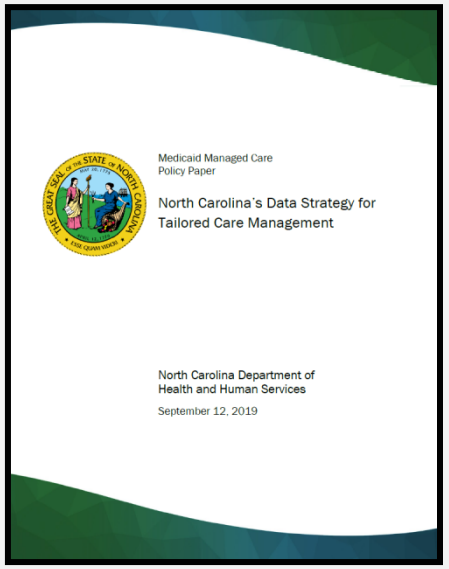
AMH+ practices or CMAs must not be owned by, or be subsidiaries of, BH I/DD Tailored Plans.

Information about the Tailored Care Management Model

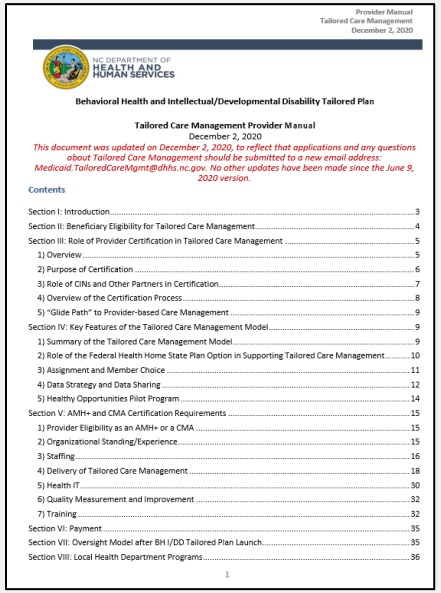
Key documents can be found on the NC DHHS Medicaid webpage.



May 2019: [Concept Paper]



September 2019: [Data Strategy Paper]



June/December 2020*: Final [Provider Manual] and [Application Questions]

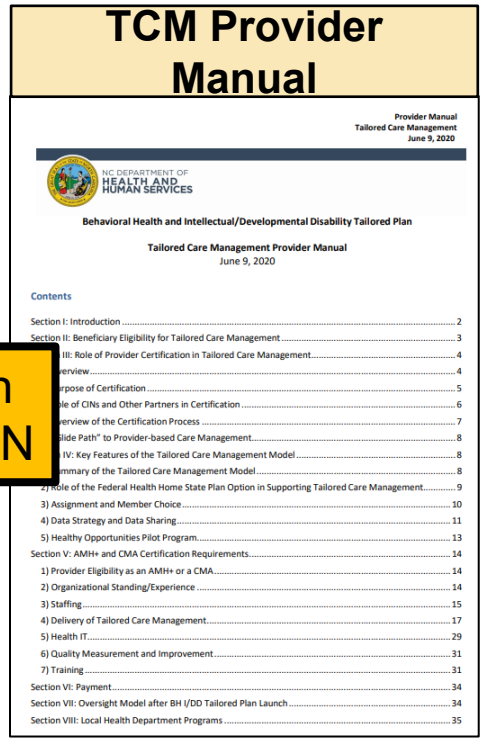
**In December 2020, the Department made minor updates to the Provider Manual and application questions released in June 2020 to reflect an updated email address for submitting applications.*

TCM Data Strategy Source Documents

The TCM Provider Manual and the BH I/DD TP RFA are the source documents for the included design requirements and dataflows. The TCM Data Strategy FAQ and Care Management Data System Guidance also discuss the data exchange and HIT requirements

Providers can work with a CIN

TCM Provider Manual



Provider Manual
Tailored Care Management
June 9, 2020

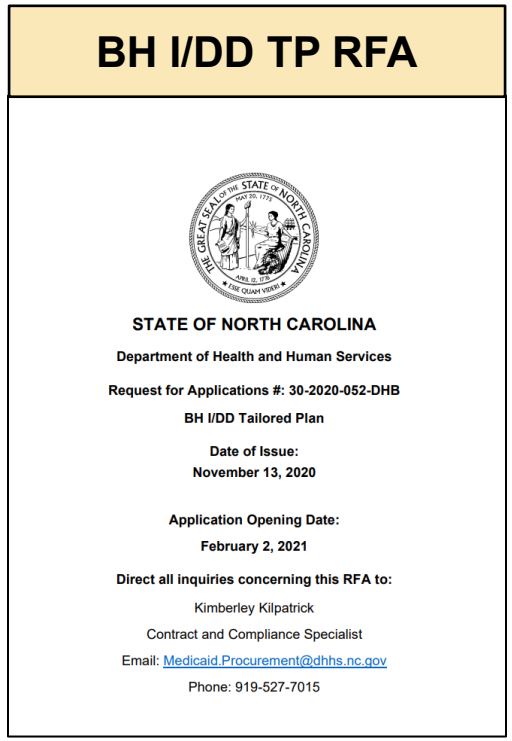
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Behavioral Health and Intellectual/Developmental Disability Tailored Plan

Tailored Care Management Provider Manual
June 9, 2020

Contents

BH I/DD TP RFA



STATE OF NORTH CAROLINA

Department of Health and Human Services

Request for Applications #: 30-2020-052-DHB

BH I/DD Tailored Plan

Date of Issue:
November 13, 2020

Application Opening Date:
February 2, 2021

Direct all inquiries concerning this RFA to:

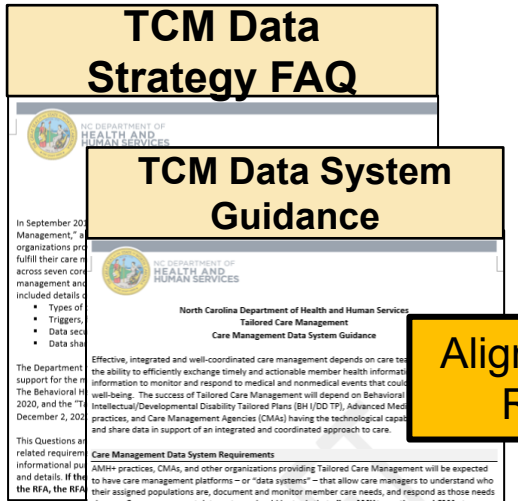
Kimberley Kilpatrick

Contract and Compliance Specialist

Email: Medicaid.Procurement@dhhs.nc.gov

Phone: 919-527-7015

TCM Data Strategy FAQ



NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

TCM Data System Guidance

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

North Carolina Department of Health and Human Services
Tailored Care Management
Care Management Data System Guidance

Effective, integrated and well-coordinated care management depends on care te… the ability to efficiently exchange timely and actionable member health informa… information to monitor and respond to medical and nonmedical events that coul… well-being. The success of Tailored Care Management will depend on Behavioral… Intellectual/Developmental Disability Tailored Plans (BH I/DD TP), Advanced Med… practices, and Care Management Agencies (CMAs) having the technological capab… and share data in support of an integrated and coordinated approach to care.

Care Management Data System Requirements

AMH+ practices, CMAs, and other organizations providing Tailored Care Management will be expected to have care management platforms – or "data systems" – that allow care managers to understand who their assigned populations are, document and monitor member care needs, and respond as those needs change. Care management data systems should be tools that **allow AMH+ practices and CMAs** to:

- ☐ Maintain up-to-date records of assigned members, the care managers those members are assigned to, and their interactions;
- ☐ Consume and store patient data;
- ☐ Perform analyses on data to share patient health needs, potential indicators of changing needs (e.g., new visits with specialists, new medications) and potential care gaps (e.g., missed appointments, flagging outdated assessments or care plans, gaps in medication adherence);
- ☐ Maintain care management documentation (e.g., assessments, care plans, care manager interaction notes);
- ☐ Reporting on care management performance, both internally (e.g. supervisor reporting) and externally (e.g., encounter data with BH I/DD TPs, quality reporting with BH I/DD TPs).
- ☐ Transmitting a practice's care management data to another selected system, if needed; and
- ☐ Provide access to - and electronically share, if requested - member records (e.g., assessments, care plans, summary of care documentation) with the member's care team to support coordinated care management, as well as the member.[1]

Care management data systems may be part of – or separate from – an organization's Electronic Health Record (EHR) or clinical system of record, or other analytic and reporting tools. However, the most effective care management data systems will be integrated with an organization's EHR or clinical system of record to support responsive and informed care delivery; they may also link to Admission, Discharge, and Transfer (ADT) data sources to help care managers centrally track unexpected service needs.

Align with AMH Data Requirements

1. North Carolina's "TCM Provider Manual". December 2, 2020. https://files.nc.gov/ncdma/Tailored-Care-Management-Provider-Manual20201202.pdf.
2. North Carolina's Behavioral Health I/DD Tailored Plan RFA. Nov. 13, 2020. https://www.ips.state.nc.us/IPS/AGENCY/PDF/13929701.pdf
3. TCM Care Management Data System Guidance. July 13, 2021. https://medicaid.ncdhhs.gov/media/9913/download?attachment
4. TCM Data Strategy FAQ. July 2021. https://medicaid.ncdhhs.gov/media/9912/download?attachment

Tailored Care Management: New Info Released (March-May)

Tailored Care Management Website

Updated Guidance on Tailored Care Management

- Optional HUP Supplement
- Rate Build-Up
- Capacity Building
- CIN Letter of interest*

TCM Provider 101 Series:
Fridays 12pm-1pm October-December 2021

- Community Inclusion Addendum to the TCM Provider Manual
- TP Eligible by County Data
- Conflict-Free TCM Guidance
- 54 Providers Pass Desk Review for TCM

Three Ways to Request to Move to NC Medicaid Direct Process

There are three ways to submit the Request to Move to NC Medicaid Direct Process:

1. Service Associated Requests - Providers should submit Service Associated Requests for Beneficiary's that need an immediate service only available in NC Medicaid Direct and/or LME-MCO.
   a. The request must be submitted by a Provider with the Beneficiary's consent requesting specific services only available through the Tailored Plan
   b. A Service Authorization Request (SAR) or Treatment Authorization Request (TAR) is required to be submitted as supporting documentation for service associated requests
   c. Processing time: Within 24 hours, the request is sent to the Tailored Plan and the **individual is moved to Medicaid Direct within one business day retroactively to the date of the request**

2. Non-Service Associated Requests – Provider Form
   a. Processing time:
      i. **5 days** for **Provider** forms
      ii. **The individual is enrolled in NC Medicaid Direct effective the 1st of the following month** for Provider and Beneficiary Non-Service Associated Request

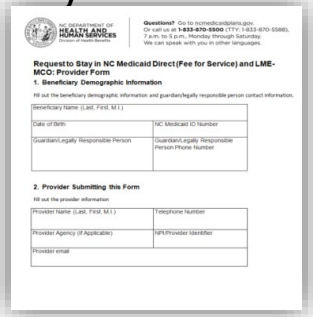
3. Non-Service Associated Requests – Beneficiary Form
   a. Processing time:
      i. **8 days** for **Beneficiary** forms

Option 1: A provider can submit the Provider Form on behalf of a member, with a Service Associated Request

Step 1

A provider completes and submits the form to the Enrollment Broker on a member's behalf, with the member or legal guardian's signature.

Provider will attach a Service Authorization Request for the Tailored Plan only service they intend to provide.



Request to Stay in NC Medicaid Direct (Fee for Service) and LME-MCO: Provider Form

1. Beneficiary Demographic information

Fill out the beneficiary demographic information and guardian/legally responsible person contact information.

Beneficiary Name (Last, First, M.I.)	
Date of Birth	NC Medicaid ID Number
Guardian/Legally Responsible Person	Guardian/Legally Responsible Person Phone Number

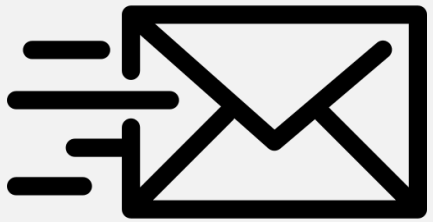
2. Provider Submitting this Form

Fill out the provider information

Provider Name (Last, First, M.I.)	Telephone Number
Provider Agency (if Applicable)	NPI/Provider Identifier
Provider email	

Step 2

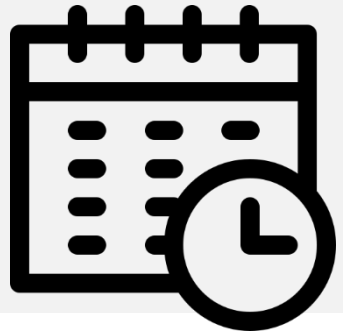
- Within 24 hours, the request is sent to the Tailored Plan (or Beacon prior to TP launch).



Step 3

The **individual is moved within one business day to the Tailored Plan or Medicaid Direct retroactively to the date of the request**

The Tailored Plan or Medicaid Direct Vendor will review the Service Authorization Request for Medically Necessity.

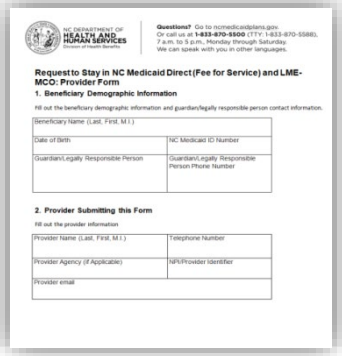


Option 2: A provider can submit the Provider Form on behalf of a member

Step 1

A provider completes and submits the form to the Enrollment Broker on a member's behalf, with the member or legal guardian's signature.

Provider will explain why they think a member will be eligible for a BH I/DD Tailored Plan in the future.



NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

Questions? Go to ncmedicaidplans.gov.
Or call us at 1-833-870-5500 (TTY: 1-833-870-5588), 7 a.m. to 5 p.m., Monday through Saturday.
We can speak with you in other languages.

Request to Stay in NC Medicaid Direct (Fee for Service) and LME-MCO: Provider Form

1. Beneficiary Demographic Information

Fill out the beneficiary demographic information and guardian/legally responsible person contact information.

Beneficiary Name (Last, First, M.I.)	
Date of Birth	NC Medicaid ID Number
Guardian/Legally Responsible Person	Guardian/Legally Responsible Person Phone Number

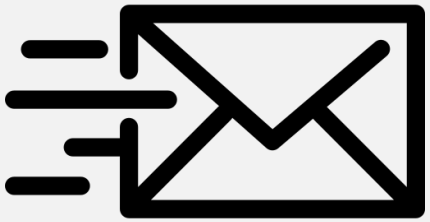
2. Provider Submitting this Form

Fill out the provider information

Provider Name (Last, First, M.I.)	Telephone Number
Provider Agency (if Applicable)	NPI/Provider Identifier
Provider email	

Step 2

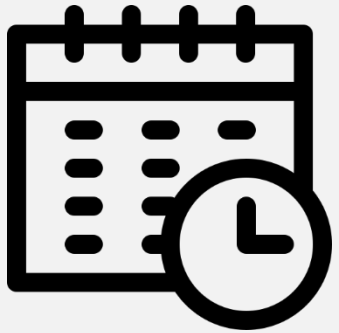
NC Medicaid will receive the form within 24 hours of submission.



Step 3

NC Medicaid will determine if a member is eligible for a BH I/DD Tailored Plan within 5 days.*

The member will be notified of the decision and moved automatically if the request is approved.

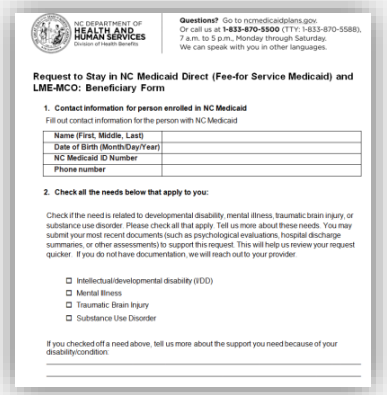


Option 3: A member or their legal guardian can submit the Beneficiary Form

Step 1

A member or their legal guardian completes and submits the form to the Enrollment Broker.

They will explain why they think they will be eligible for a BH I/DD Tailored Plan in the future.



NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

Questions? Go to ncmedicaidplans.gov.
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We can speak with you in other languages.

Request to Stay in NC Medicaid Direct (Fee-for Service Medicaid) and LME-MCO: Beneficiary Form

1. **Contact information for person enrolled in NC Medicaid**

Fill out contact information for the person with NC Medicaid

Name (First, Middle, Last)	
Date of Birth (Month/Day/Year)	
NC Medicaid ID Number	
Phone number	

2. **Check all the needs below that apply to you:**

Check if the need is related to developmental disability, mental illness, traumatic brain injury, or substance use disorder. Please check all that apply. Tell us more about these needs. You may submit your most recent documents (such as psychological evaluations, hospital discharge summaries, or other assessments) to support this request. This will help us review your request quicker. If you do not have documentation, we will reach out to your provider.

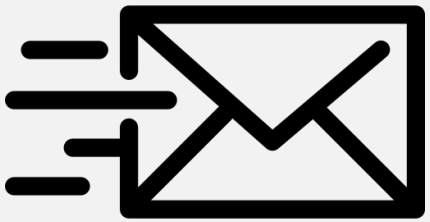
- ☐ Intellectual/developmental disability (I/DD)
- ☐ Mental Illness
- ☐ Traumatic Brain Injury
- ☐ Substance Use Disorder

If you checked off a need above, tell us more about the support you need because of your disability/condition:

Step 2

NC Medicaid will receive the form within 24 hours of submission.

NC Medicaid may contact your provider for more information.



Step 3

NC Medicaid will determine if they are eligible for a BH I/DD Tailored Plan within 8 days. *

They will be notified of the decision and moved automatically if their request is approved.

Request to Move to TP or NC Medicaid Direct: Service Associated Requests and Non-Service Associated Requests

	Service Associated Requests	Non-Service Associated Requests
Who can Submit:	• The request must be submitted by a Provider, who intends to provide services, with the Beneficiary's consent requesting specific services only available through the Tailored Plan	• The request may be submitted by a Provider with the Beneficiary's consent using the form provided by DHHS • The request may be submitted by a Beneficiary using the form provided by DHHS

How to Submit:	• A provider will submit a Service Associated Request online digitally at ncmedicaidplans.gov using the *Request to Move to NC Medicaid Direct (Fee for Service) or LME-MCO: Provider Form*
	• A Service Authorization Request (SAR) or Treatment Authorization Request (TAR) is required to be submitted as supporting documentation for service associated requests
		• Non-Service Associated Requests can be submitted online digitally at ncmedicaidplans.gov using one of these forms:
		  • **Members:** fill out and sign *Request to Move to NC Medicaid Direct (Fee for Service) or LME-MCO: Beneficiary Form*
		  • **Providers**: fill out and sign the *Request to Move to NC Medicaid Direct (Fee for Service) or LME-MCO: Provider Form*

Processing Time:	• Within 24 hours, the request is sent to the Tailored Plan (or Beacon prior to TP launch) and the **individual is moved within one business day retroactively to the date of the request**	• **5 days** for **Provider** forms • **8 days** for **Beneficiary** forms • **The individual is enrolled in NC Medicaid Direct effective the 1st of the following month**

Provider Training Regarding TP and Medicaid Direct Transitions

The State is conducting training with PHPs as well as AHEC, to provide the Provider Community with additional information on the Request to Move to NC Medicaid Direct process

- Providers should use the Service Associated Request process if it's a beneficiary that needs an immediate Service within NC Medicaid Direct and/or LME-MCO

- Providers can reference the Request to Move to NC Medicaid Direct Process Fact Sheet that is posted on the Provider Playbook Fact Sheet webpage.

Provider Support for the Request to Move to NC Medicaid Direct Process

Provider Question Type	Organization to Contact
• How to submit a Service Associated Request or Non-Service Associated Request • Status of Non-Service Associated Request that has been submitted within 5 days (if submitted by provider) or within 8 days (if submitted by beneficiary)	**Enrollment Broker** at 1-833-870-5500 (TTY: 711 or RelayNC.com)
• Status of Non-Service Associated Request that has been previously submitted over 6 days ago (if submitted by provider) or over 9 days ago (if submitted by beneficiary). • Status of Service Associated Request that has been previously submitted over 2 business days ago	**Provider Ombudsman** at Medicaid.ProviderOmbudsman@dhhs.nc.gov, or 866-304-7062.

For more information, please reference the Request to NC Medicaid Direct Process Fact Sheet

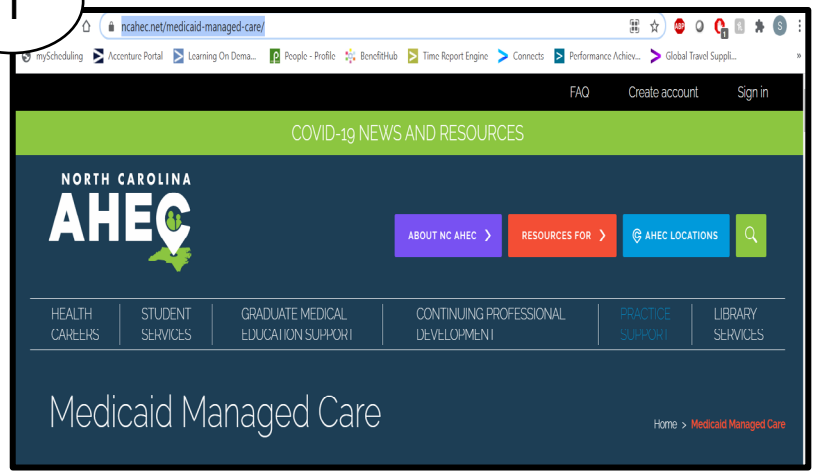
Providers and beneficiaries can find the forms online


QUESTIONS?

APPENDIX

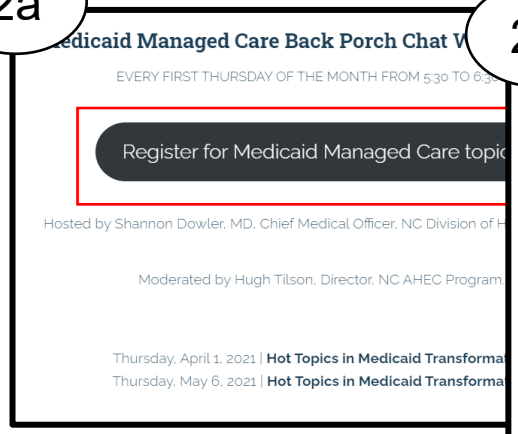
How To Sign up for the Back Porch Chat Webinar Series

1

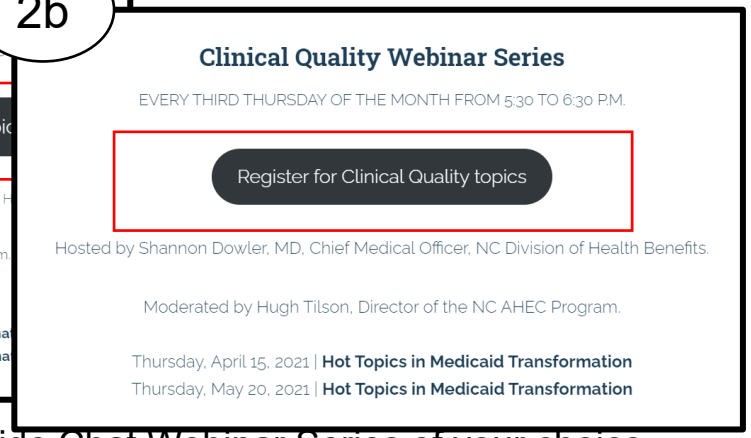


1. Navigate to the North Carolina AHEC Medicaid Managed Care page

2a



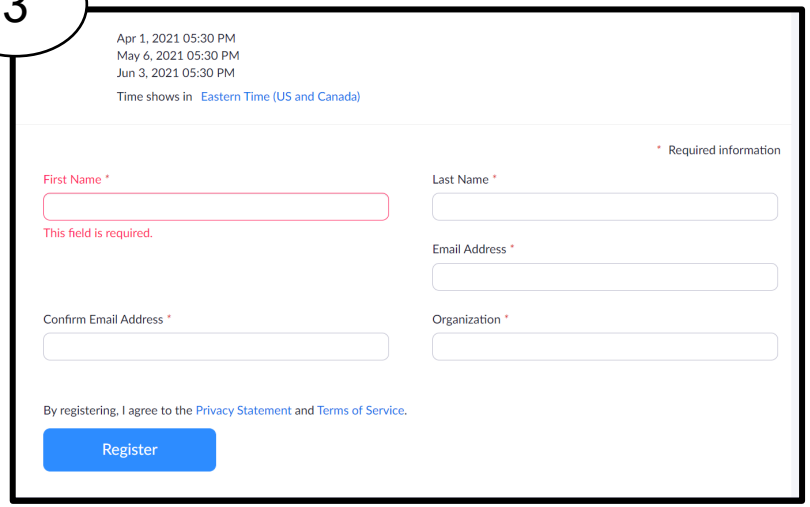
2b



2. Scroll down to the Fireside Chat Webinar Series of your choice

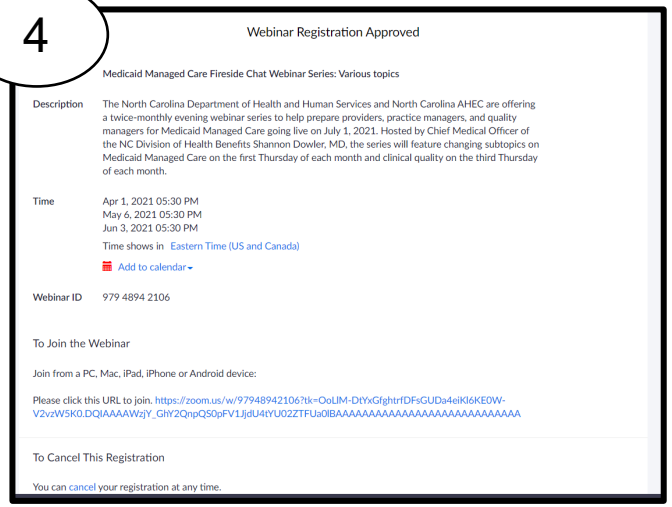
2b. Click on “Register for Medicaid Managed Care topics” or “Register for Clinical Quality topics”

3



3. Fill out all the required information and click register

4



4. When you see this page, your registration is successful.

Provider Resources

- NC Medicaid Managed Care Website
  - medicaid.ncdhhs.gov
  - Includes County and Provider Playbooks
  - Fact Sheets
  - Day One Quick Reference Guide
- NC Medicaid Help Center
  - medicaid.ncdhhs.gov/helpcenter
- Practice Support
  - ncahec.net/medicaid-managed-care
  - NC Managed Care Hot Topics Webinar Series, hosted by Dr. Dowler on the first and third Thursday of the month
- Regular Medicaid Bulletins
  - medicaid.ncdhhs.gov/providers/medicaid-bulletin

What should Providers do if they have issues?

1

Check in NCTracks for the Beneficiary's enrollment (Standard Plan or Medicaid Direct) and Health Plan

If you still have questions, call the NCTracks Call Center: 800-688-6696

2

Connect with the Health Plan (PHP) for coverage, benefits, and payment questions.

You can find a list of health plan contact information at health-plan-contacts-and-resources
Also, please refer to the Day One Provider Quick Reference Guide for more information on how to contact PHPs

3

Consult with the Provider Ombudsman on unresolved problems or concerns.

Call 866-304-7062 or email Medicaid.ProviderOmbudsman@dhhs.nc.gov

Day 1 Quick Reference Guide

VERIFICATION OF ELIGIBILITY AND PLAN

- **NCTracks:** Providers will be able to verify eligibility and Managed Care enrollment through the NCTracks Recipient Eligibility Verification function available in the Provider Portal
- **Real Time Eligibility Verification Method**
  a. Log into the NCTracks Provider Portal: https://www.nctracks.nc.gov/ncmmisPortal/loginAction?flow=PP
  b. Follow the Eligibility > Inquiry navigation
  c. Populate the requested provider, recipient and time period information
- **NCTracks Call Center:** 800-688-6696

PROVIDER PORTAL / PROVIDER SERVICES

- **AmeriHealth Caritas**: https://navinet.navimedix.com / Provider Services: 888-738-0004
- **Carolina Complete**: https://network.carolinacompletehealth.com / Provider Services: 833-552-3876
- **Healthy Blue**: https://provider.healthybluenc.com or https://www.availity.com / Provider Services: 844-594-5072
- **United Healthcare**: https://www.uhcprovider.com / Provider Services: 800-638-3302
- **WellCare**: https://provider.wellcare.com / Provider Services: 866-799-5318
- **NC Medicaid Provider Playbook**: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care

PRIOR AUTHORIZATIONS

- **AmeriHealth Caritas: Online**: Provider Portal / **Phone**: 833-900-2262 / **Pharmacy**: 866-885-1406
- **Carolina Complete: Online**: Provider Portal / **Phone:** 833-552-3876 / **Pharmacy:** 833-585-4309
- **Healthy Blue: Online**: Provider Portal / **Phone:** 844-594-5072 / **Pharmacy**: 844-594-5072
- **United Healthcare: Online:** UHCProvider.com / **Pharmacy: Phone:**855-258-1593 **Online**: CoverMyMeds: https://www.covermymeds.com/main/prior-authorization-forms/optumrx/; SureScripts: https://providerportal.surescripts.net/ProviderPortal/optum/login; Pharmacy Resources and Physician Administered Drugs: UHCprovider.com
- **WellCare: Online**: Provider Portal / **Phone:** 866-799-5318 / **Pharmacy**: Fax: 800-678-3189 **or** SureScripts: https://providerportal.surescripts.net/providerportal/

Day 1 Quick Reference Guide

CLAIMS

- **AmeriHealth Caritas: Online**: https://navinet.navimedix.com / **Phone**: 888-738-0004
- **Healthy Blue: Online:** www.availity.com / **Phone**: 844-594-5072
- **Carolina Complete: Online**: https://network.carolinacompletehealth.com
- **United Healthcare: Online**: https://www.uhcprovider.com / **Phone**: 800-638-3302
- **WellCare: Online**: https://www.wellcare.com/en/North-Carolina/Providers/Medicaid/Claims / **Phone:** 866-799-5318

Two Claims Submission Fact Sheets are available on the Provider Playbook at: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care that address filing managed care claims.

NON-EMERGENCY MEDICAL TRANSPORTATION & NON-EMERGENCY AMBULANCE TRANSPORTATION

- **AmeriHealth Caritas, Carolina Complete, Healthy Blue, United Healthcare:**

ModivCare Health Care Provider Line: 855-397-3606 / ModivCare Transportation Provider Line: 855-397-3604

- **WellCare**: One Call Health Care Provider Line: 877-598-7602 / One Call Transportation Provider Line: 877-598-7640

If you are helping a member arrange transportation, call the PHP Member Services line on the member's Medicaid ID card.

PROVIDER OMBUDSMAN

Medicaid Managed Care Provider Ombudsman: **Phone:** 866-304-7062 / **Online:** Medicaid.ProviderOmbudsman@dhhs.nc.gov

HEALTH PLAN QUICK REFERENCE GUIDE LOCATION

- AmeriHealth Caritas: https://www.amerihealthcaritasnc.com/assets/pdf/provider/provider-reference-guide.pdf
- Carolina Complete: https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCHNCurrent-PDF-QRG-Form.pdf
- Healthy Blue: https://provider.healthybluenc.com/docs/gpp/NC_CAID_QuickReferenceGuide.pdf
- United Healthcare: https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/nc/training/NC-Medicaid-QRG.pdf
- WellCare: https://www.wellcare.com/North-Carolina/Providers/Medicaid