NC Medicaid Managed Care

Provider Playbook

NC Medicaid

Fact Sheet

What Providers Need to Know Part 2: After Tailored Plan Launch

Post-launch Checklist and Information

The launch of Behavioral Health and Intellectual/Developmental Disabilities (I/DD) Tailored Plan (Tailored Plans) is July 1, 2024. A small percentage of Tailored Plan eligible beneficiaries will remain in NC Medicaid Direct. This fact sheet supplements the Part 1 fact sheet and provides additional information providers need to know after the launch of Tailored Plans.

KEY DATES

The following list includes key dates that providers should be aware of:

- **April 13, 2024**: Auto-enrollment
- **April 17, 2024:** NC Medicaid Enrollment Broker begins mailing transition notices
- **April 15 – May 15, 2024:** Tailored Plan choice period
- **May 16, 2024:** Tailored Plan beneficiaries can begin scheduling NEMT appointments for on or after July 1, 2024
- **May 16, 2024**: Primary care provider (PCP) auto-assignment
- **May 23, 2024 – June 7, 2024:** Tailored Plans mail welcome packets, Member handbooks and ID cards
- **June 1, 2024**: Nurse, behavioral health and pharmacy call lines go live
- **July 1, 2024**: NC Medicaid Tailored Plan launch
- **Sept. 30, 2024:** Final date Tailored Plans will relax medical prior authorization requirements and final date Tailored Plans must honor existing and active medical prior authorizations on file with NC Medicaid (or until the end of the authorization period, whichever occurs first)
- **Sept. 30, 2024:** Final date Tailored Plans will relax pharmacy prior authorization requirements. Tailored Plans must honor existing and active pharmacy prior authorizations on file with NC Medicaid Direct through the end of the authorization period.
- **Sept. 30, 2024:** Last date to submit claims for Medicaid-enrolled out-of-network providers that will pay equal to that of in-network providers.

- **Jan. 31, 2025:** Last date to submit claims for Medicaid-enrolled out-of-network providers that will require authorizations equal to that of in-network providers.

KEY REMINDERS FOR PROVIDERS

All providers are strongly encouraged to complete the following checklist of key actions after Plan launch. Detailed information for some of these items is available on the following pages.

- Make sure your office staff know with which health plans you are contracted.
- Continually review the NCTracks provider record for each applicable individual provider and organization for accuracy and submit changes using the Manage Change Request (MCR) process. Changes must be reported within 30 calendar days.
- Know where to submit claims based on the beneficiary's assignments on the date the service is rendered.
- For each health plan under contract, be sure enrollment in the health plan's electronic funds transfer program is complete.
- Assist beneficiaries with the transition to Tailored Plans following the guidance below.

PROVIDER CONTRACTING REMINDERS

Health plan contracting is an ongoing process. There are consequences for non-participation impacting both providers and members. For example, PCPs who do not contract with health plans risk losing patients, as members will choose a PCP from their health plan's in-network providers. Health plans will auto-assign members to providers in their network providers if a beneficiary does not select a PCP.

NC Medicaid strongly encourages providers, especially PCPs and Advanced Medical Homes (AMHs), to work with the respective Tailored Plans to meet the contracting deadlines to support service continuity for patients.

For more information on contracting with a health plan, contact them directly. Contact information is located on the Medicaid website at Health Plan Contacts and Resources Page.

MAKE SURE INFORMATION IS CORRECT

NC Medicaid participating providers are contractually required to update their NCTracks record within 30 days of any change.

The obligation to report includes any change in information contained in the NCTracks provider enrollment record, as well as any adverse action against the provider or any of its officers, agents or employees.

To remain compliant and maintain accuracy of the information supplied to the health plans and members, providers should regularly review their provider record in NCTracks. Changes may be submitted using the MCR process available in the NCTracks Secure Provider Portal. Health plans can only update certain information in their files upon receipt of the information from NCTracks.

Review the NC Medicaid Provider Administrative Participation Agreement here or a recent publication about reporting changes here.

Confirm individual providers are correctly affiliated to all organizations billing on their behalf and to each appropriate location within that organization. This is done through a review of the individual provider's NCTracks record and is essential to ensure provider directories display accurate results. Information will display in the Medicaid Provider and Health Plan Lookup Tool. When a member searches for an individual doctor at a specific organization's location, the affiliated information from NCTracks is used in the search. Therefore, all individual providers should check their affiliations not only to the group NPI, but also to the specific location(s) where services are rendered.

KNOW HOW TO SUBMIT CLAIMS

Claims for dates of service prior to July 1, 2024, should be submitted as they are today, through NCTracks or LME/MCOs. A limited set of services are carved out of managed care and should continue to be billed through NCTracks even after Tailored Plan launch. These include dental services, eyeglasses and Child Development Services Association (CDSA) services included on an Individualized Family Service Plan (IFSP) provided by independent practitioners. Review the benefits and services that all plans offer and the benefits and services carved out of health plan networks here.

For dates of service beginning July 1, 2024, claims routing depends on a member's enrollment at time of service and the services provided.

Claims for beneficiaries enrolled in NC Medicaid Direct should continue to be submitted to NCTracks or LME/MCO for behavioral health services.

Claims for members enrolled in a Tailored Plan should be submitted as instructed by the assigned health plan shown on their member ID card and validated through the NCTracks Recipient Eligibility Verification methods, unless the service provided is a carved-out service.

Two "Claims Submission" provider fact sheets are available in the Provider Playbook that addresses how managed care claims are filed.

ASSIST MEMBERS WITH THE TRANSITION

It is important all office staff know which health plans providers participate with and take the initiative to assist patients with the transition to managed care. Please note:

- Tailored Plan members may change their PCP at any time without cause until January 31, 2025. Members can choose a different PCP from the one they received during auto-assignment. After January 31, 2025, Members can change their PCP once a year without cause. Contact Information can be found on the Health Plan Contacts and Resources Page.
- Once enrolled with a Tailored Plan, members will receive a Member Welcome Packet, Member Handbook and Member ID Card from their Tailored Plan. Follow these steps when an NC Medicaid beneficiary presents at your office:
  - Verify eligibility, PCP and health plan enrollment using the NCTracks Recipient Eligibility Verification/Response or by calling the NCTracks Automated Voice Response System (AVRS) at 800-723-4337.

    To mitigate any confusion associated with newly issued NC Medicaid Member ID cards, providers and pharmacies should always verify eligibility through NCTracks and not rely solely on the information shown on a Member ID.

  - Health plans are required to generate an identification card for each member enrolled in their health plan that contains the member's NC Medicaid ID number. Some health plans also include their health plan member ID as well. However, member ID cards are not required to provide services including pharmacies. **Therefore, members should not be turned away due to the lack of a Member ID card in their possession.**
- Confirm that your office participates with the member's Tailored Plan.
- If you are not the assigned PCP for the member but are in-network for the Tailored Plan, you can render and be paid for primary care services.
- If the member would like to have you as their assigned PCP, they should call their health plan to have them assigned to you.
- If you are a non-participating provider for the member's Tailored Plan, you may render services. Special protection is afforded to non-network providers (see the Transition of Care section below). If a good-faith contracting effort has been made by the health plan and you declined to participate, then you are subject to receive 90% of the Medicaid fee-for-service rate. Good faith contracting requirements and information are available in the contract and plan policies

TRANSITION OF CARE PROTECTIONS IMPACTING PROVIDERS

As a provider, it is important you are aware of the transition of care protections that impact providers. Please note:

- The Tailored Plan will relax medical prior authorization requirements and honor existing and active medical prior authorizations on file with NC Medicaid Direct for services covered by the health plan for the first 91 days after launch (Sept. 30, 2024) or until the end of the authorization period, whichever occurs first.
- The Tailored Plan will relax pharmacy prior authorization requirements for the first 91 days after launch (Sept. 30, 2024). Tailored Plans must honor existing and active pharmacy prior authorizations on file with NC Medicaid Direct through the end of the authorization period.
- For the first 91 days after launch (Sept. 30, 2024), the Tailored Plan will pay claims and authorize services for Medicaid-enrolled out-of-network providers equal to that of in-network providers until end of episode of care or 60 days, whichever is less (extended transition periods may apply for circumstances covered in N.C. Gen. Stat. § 58-67-88(d), (e), (f), and (g).).
- If a member transitions between health plans after Aug. 1, 2024, a prior authorization authorized by their original health plan will be honored for the life of the authorization by their new health plan.
- For more information see the Transition of Care webpage on the NC Medicaid website.

WHAT IF MEMBERS HAVE QUESTIONS?

Once a member is enrolled with a Tailored Plan, a Welcome Packet, Member Handbook and a new Member ID card will be mailed to them. If members have questions about their health plan, want to change their PCP, AMH, TCM or have questions about services covered, they should contact their health plan.

Contact information for health plans can be found at the number on their new Medicaid card or under the Health Plan Contacts and Resources.

Members who want to change their health plan should contact the NC Medicaid Enrollment Broker at 833-870-5500, (TTY: 833-870-5588), 7 a.m. to 5 p.m., Monday through Saturday.

Beneficiaries can contact the NC Medicaid Ombudsman if they have questions or problems the health plan or provider cannot answer. Call **877-201-3750** or visit ncmedicaidombudsman.org.

WHAT IF I HAVE QUESTIONS?

Additional resources for providers on the transition to NC Medicaid Managed Care can be found in the NC Medicaid Help Center, the Provider Playbook and on the Medicaid Transformation website. The **Day One Quick Reference Guide** can also be found on the Provider Playbook Fact Sheet page.

For general provider inquiries and complaints regarding health plans, contact the **Provider Ombudsman** at Medicaid.ProviderOmbudsman@dhhs.nc.gov or 866-304-7062. The Provider Ombudsman contact information is published in the health plan's provider manual.

For questions related to your NCTracks provider information, contact the NCTracks Call Center at 800-688-6696. To update your information, please log into the NCTracks Provider Portal to verify your information and submit an MCR. For all other questions, contact the NC Medicaid Contact Center at 888-245-0179.