NC Department of Health and Human Services

Crossover to NC Medicaid Managed Care/Standard Plan: LME-MCO Provider Education

Vaya Health

Friday, May 14, 2021

Today's Session

What's Covered

- Summary Overview of NC's Transition to Managed Care
- Transition of Care Concept
- Overview Activities Underway to Support Members and Providers through Crossover.
- Guidance on:
  - Identifying member's PHP
  - Submitting authorization requests
- Additional Resources

What's Not Covered

- Overview of Tailored Plan
- Specific guidance on how to enroll in PHP network
- Specific guidance on PHP benefits.
- Ongoing Transition of Care, including linkages of Standard Plan Members into LME/MCOs.
- Processes that do not directly impact member's transition.
- See Provider Playbook link in Education Section for additional education resources.

INFORMATION PROVIDED IS CURRENT AS OF THIS PRESENTATION. TRAINING MAY BE AMENDED TO PROVIDE ADDITIONAL INFORMATION OR CLARIFICATION.

OVERVIEW OF NC'S TRANSITION TO STANDARD PLANS UNDER NC MEDICAID MANAGED CARE

North Carolina's Vision for Medicaid Transformation

"To improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care that addresses both the medical and non-medical drivers of health."

Moving to NC Medicaid Managed Care

Approximately 1.6 million of the current 2.5 million Medicaid beneficiaries will transition to NC Medicaid Managed Care

- Beneficiaries will be able to choose from 5 Health Plans (aka “PHPs”)
  - AmeriHealth Caritas
  - Healthy Blue
  - United HealthCare Community Plan
  - WellCare
  - Carolina Complete Health:
    - Serving regions 3, 4, and 5

- Eastern Band of Cherokee Indians (EBCI) Tribal Option
  - Will manage the health care for North Carolina’s approximate 4,000 Tribal Medicaid beneficiaries primarily in Cherokee, Graham, Haywood, Jackson, and Swain counties

All health plans, all regions will go live on July 1, 2021

What do some of the terms mean?

NC Medicaid Direct

- New name for our current Medicaid program.
- Fee-for-service + LME/MCOs (or PACE)
- What everyone on Medicaid has now

NC Medicaid Managed Care

- The term used reference the five “prepaid health plans” or “PHPs” or “health plan”
- Also called “Standard Plan” or “Standard Plan Option.”
- Launch date (7/1/2021) is referenced as “Managed Care Launch (MCL),” “Managed Care Effective Date” or “Standard Plan Effective Date”

Tailored Plan

- Specialized plans for members with significant behavioral health needs and intellectual/developmental disabilities
- What will replace the LME/MCOs in 2022
- **NOT the focus of today’s training session.**

Overall Vision for Transition of Care Design

As beneficiaries move between delivery systems, the Department of Health and Human Services (Department or DHHS) intends to maintain continuity of care for each beneficiary and minimize the burden on providers during the transition.

The NC Transition of Care "Tridge:"

Processes established to guide transitions between Plans and Service Delivery Systems

Health Plan 1

Health Plan 2

Medicaid Direct/Tribal/LME/MCO

- Enrolling
- Disenrolling
- Tailored Plan eligible

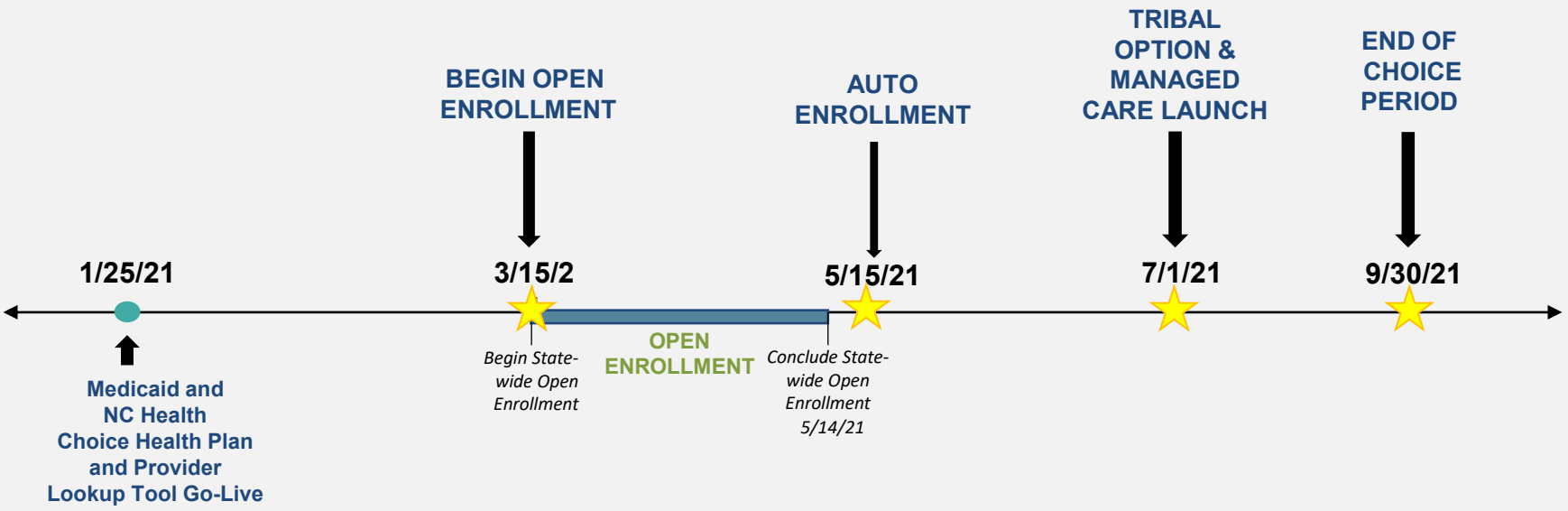
"Tridge" in Midland, Michigan: https://www.kuriositas.com/2012/01/tridge-michigans-three-way-bridge.html

Transition of Care: Two Distinct Phases

Focus of today's session

Crossover to MCL Transition of Care	One time crossover of beneficiaries eligible for NC Medicaid Managed Care on "Managed Care Implementation" or "Managed Care Launch" date (July 1, 2021)
Ongoing Transition of Care	Ongoing transition of care for beneficiaries moving between Health Plans, between Health Plan and Medicaid Direct.

Key Managed Care Milestones Timeline



BH/IDD/SA/TBI Service Comparison Table

Covered by BOTH Standard Plan and LME-MCO

State Plan BH and I/DD Services

- Inpatient behavioral health services
- Outpatient behavioral health emergency room services
- Outpatient behavioral health services provided by direct-enrolled providers
- *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*
- *Research-Based Behavioral Health Treatment*
- *Diagnostic assessments*
- *Non-hospital medical detoxification*
- *Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization*
- *Peer support*

EPSDT

*DHHS plans to add the following service(s) to the State Plan:

- Clinically managed low-intensity residential treatment services and clinically managed population-specific high-intensity residential programs (to be offered by BH I/DD Tailored Plans only)

Covered by ONLY LME-MCO (Tailored Plan at a later date)

State Plan BH and I/DD Services

- Residential treatment facility services
- *Child and adolescent day treatment services*
- *Intensive in-home services*
- *Multi-systemic therapy services*
- *Psychiatric residential treatment facilities (PRTFs)*
- *Assertive community treatment (ACT)*
- *Community support team (CST)*
- *Psychosocial rehabilitation*
- *Substance abuse intensive outpatient program (SAIOP)*
- *Substance abuse comprehensive outpatient treatment program (SACOT)*
- *Substance use non-medical community residential treatment*
- *Substance abuse medically monitored residential treatment*
- Intermediate care facilities for individuals with intellectual disabilities (ICF/IID)

Waiver Services

- Innovations waiver services
- TBI waiver services
- 1915(b)(3) services

State-Funded BH and I/DD Services

State-Funded TBI Services

Source: Section V.C Table 3 PHP Contract 7 16 2019 Amendmer

NC's TRANSITION TO MANAGED CARE: THE CROSSOVER DESIGN

NC Medicaid Transformation:
Key Transition of Care Activities For LME/MCO Members

April 2021	May 2021	June 2021	July 1, 2021: LAUNCH	Post Launch
Crossover-Education and Communication 2020 and 2021	Crossover Education and Communication	Crossover Education and Communication continues Members can begin reserving post-Launch transportation appointments through PHP call line.	PHPs conduct follow along to high need members. PHP responsible for NEMT services for Enrolled Members Providers will resubmit authorized PAs covered under 42 CFR Part 2 to PHP.	
LME/MCO Rapid Identification Process Begins	LME/MCO Rapid Identification continues	Transition Summary Sheets/Care Plan for Warm Handoff members transfer starts	Providers submit PAs with DOS post 7/1 to Member's PHP PHP must honor open FFS PAs for services covered by the PHP for no less than 90 days unless expires sooner.	
Claims and encounter transfer begin	PA data transfer begins.	NC Tracks Provider Portal reflects beneficiary's Managed Care Status and assignment LME/MCO Rapid Identification ends	Non participating provider requirements of PHPs in effect.	

Pre-MCL: Rapid Identification of LME/MCO Members who are eligible to remain with LME/MCO, but have not yet been identified in data.

April 2021	May 2021	June 2021

General Process

- NC Medicaid state team have been working to identify LME/MCO members through encounter/LME/MCO data logic are Tailored Plan eligible and therefore should remain with LME/MCO on July 1, 2021.
- Recognizing that not all Tailored Plan-eligible (LME/MCO) members will be reflected in encounter data, and authorizations for LME/MCO only services are in effect or under review close to July 1, 2021, NC Medicaid State Team and LME/MCO network have established the “Rapid Identification” Process to minimize members inappropriately transitioning to the Standard Plan.
- Starting the week of 4/19/2021, LME/MCOs will begin submitting spreadsheet of members currently authorized or in process of authorizing for LME/MCO- only service.
- LME/MCO will submit updates weekly as needed.
- LME/MCOs may submit names up through 6/21/2021
- Any member not identified by this date will transition to Standard Plan.

SACOT/SAIOP/COVID

- Members currently utilizing SACOT/SAIOP/services with authorizations waived under COVID flexibilities who have not yet been identified in encounter data are eligible to be included in this list.
- LME/MCOs will work with relevant service providers to identify and confirm potential members.

LME/MCO Specific Guidance for Provider: Vaya Health

- Vaya will contact providers of SAIOP and SACOT to obtain information when needed.

Transition of Care Design

Driving Design Priorities	Resulting In
Facilitating Uninterrupted Service Coverage	Continuity of care protections related to service authorizations and provider continuity.
Supporting Continuity of Care through Data Transfer	Automated data transfer of prior authorizations, claims/encounter data and pharmacy lock-in data.
Clear and Organized Communication Between Entities	Communication protocols between health plans and with LME/MCOs, CCNC and other entities engaged with the transition.
Establishing Additional Safeguards for High Need Members	Rapid follow up at Launch, warm handoffs between entities and transfer of additional Member information.
Member and Provider Education	Transition of care-specific educational materials, webinars and call center scripting.

Facilitating Uninterrupted Service Coverage

Prior Authorization Requests for DOS Prior to Managed Care Date

- LME/MCOs will continue to process Service Authorization/Prior Authorization* requests for members enrolled at 11:59 prior to MCL.
- Open and recently closed PAs will be transferred to Member's PHP to help ensure continuity of care.**
- PHPs are required to honor open PAs for services covered by Standard Plan/PHP up to 90 days after launch, unless auth expires sooner.
- If PHP terminates open PA after 90 days, it must provide appeal rights.

*also referred to as "PA" or "Auth"

**Unless under the scope of 42 CFR Part 2. Prior Authorizations with 42 CFR Part 2 content will not be transferred.

Outpatient Behavioral Health Services at Transition

- Outpatient Behavioral Health Services Provided by Directly-Enrolled Providers: Units will reset to zero.

Unmanaged Visits for Outpatient Behavioral Health Services	As referenced in the Revised and Restated RFP, PHPs are required to adhere to Department's Clinical Coverage Policy 8C, Outpatient Behavioral Health Services Provided by Direct-enrolled Providers. This policy states in relevant part: Outpatient behavioral health services coverage is limited to eight unmanaged outpatient visits for adults and 16 unmanaged outpatient visits for children per state fiscal year (inclusive of assessment and Psychological Testing codes). For members who are authorized for services under this Clinical Coverage Policy at Managed Care Launch (MCL), **the unmanaged visit count shall reset to zero**. PHPs are otherwise required to adhere to Clinical Coverage Policy 8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers.

Authorization Requests for DOS Prior to Managed Care Date

Member's Managed Care Date (Managed Care Effective Date = MC Effective)

Member Covered by LME-MCO

Scenario 1: Provider submits Auth request prior to Managed Care Effective Date for member transitioning to PHP for service covered by both LME/MCO and PHP. LME/MCO authorizes services as clinically indicated. Authorization will be transferred to PHPs as part of daily PA transfer file.*

*unless under scope of 42 CFR Part 2.

Member Covered by PHP

Scenario 1. PHP required to honor LME/MCO authorization minimally the first 90 days, unless expires sooner. If Authorization extends beyond 90 days and the PHP terminates, it must issue appeal rights.

Scenario 1: LME-MCO generated PA for service also covered by PHP

Scenario 2: Provider submits Auth request prior to MC Effective Date for member transitioning to PHP for service ONLY covered by LME-MCO. LME/MCO may process but benefit may not be available in Standard Plan.

Scenario 2

Scenario 2: Benefit not available. PHP has no capacity or responsibility to provide.
*EPSDT rules apply

Scenario 3: Provider may submit retroactive Auth request for pre MC effective dates of service (DOS) for a member formerly enrolled in LME/MCO, now enrolled in PHP. LME/MCO may only authorize for pre MC effective dates of service.

Scenario 3

Scenario 3: Provider may submit separate Auth request directly to PHP.

Auth Requests at Crossover: What Providers Need to Know

- **Confirm that a Member is Transitioning to a Standard Plan**
  - Many members currently served by the LME/MCO will remain with the LME/MCO.
  - A member's Managed Care Status and (if applicable) PHP selection/assignment will be available through NCTracks Provider Portal in June.
  - **For Provider Portal Guidance:** See Job Aid *PHP Eligibility/Enrollment for Providers* in NC Tracks Provider Portal

- **Know Member's Transition Date/Managed Care Effective Date**
  - For members transitioning to Standard Plan, this date will be **7/1/2021**

- **Be Clear on What and When You are Submitting:**
  - **Service Auth submitted before Managed Care (MC) Effective Date?**
    - Send to LME/MCO
    - LME/MCO specific benefits may be authorized but may not be available in Standard Plan after MC Effective Date.
    - If submitting authorization impacted by 42 CFR Part 2, please see *Data Impacted by 42 CFR Part 2* slide later in this deck.
  - **Service Auth for Standard Plan member submitted after MC Effective Date?**
    - Will submit to PHP.
    - If retroactive request includes date of service (DOS) prior to MC Effective Date may submit to LME/MCO for only pre-MC Effective Date dates.

- **To submit Service Auth/ Request on or after MCL**
  - Follow instructions provided directly by the PHP
  - Coming Soon! All PHP instructions in one place: https://medicaid.ncdhhs.gov/providers

Stop Lights for Attempted Auth Requests to LME-MCO after Managed Care Effective Date

Intensive Provider Education	• Ensure providers know about PA submission requirements. • Ensure providers have information needed to resubmit PA request to proper PHP
Notification: Auto-Information Message	• If a provider attempts to enter information for a member who is now enrolled in Standard Plan, it ***may*** not find member in PA portal and will see banner message instructing where to get additional information.
Informed Call Center Staff	• LME/MCO center staff will be informed on how to guide both members and providers.

Appeals at Crossover

- Generally, adverse determination process and appeal rights will be processed as typical.
- Members appealing initial service request denials will be instructed on option to submit new request to PHP.
- PHPs will be required to honor Continuation of Benefits/Maintenance of Service on covered benefits until can reassess and either approve ongoing services or issue appeal rights.
- EPSDT still requirements apply.

Processing Payment at Crossover: What Providers Need to Know

- Claims for dates of service prior to the member's Standard Plan Effective Date should continue to be submitted to the LME/MCO.

- Claims for dates of service after the member's Standard Plan Effective Date should be submitted to the member's PHP following applicable PHP protocol as provided in provider enrollment materials.

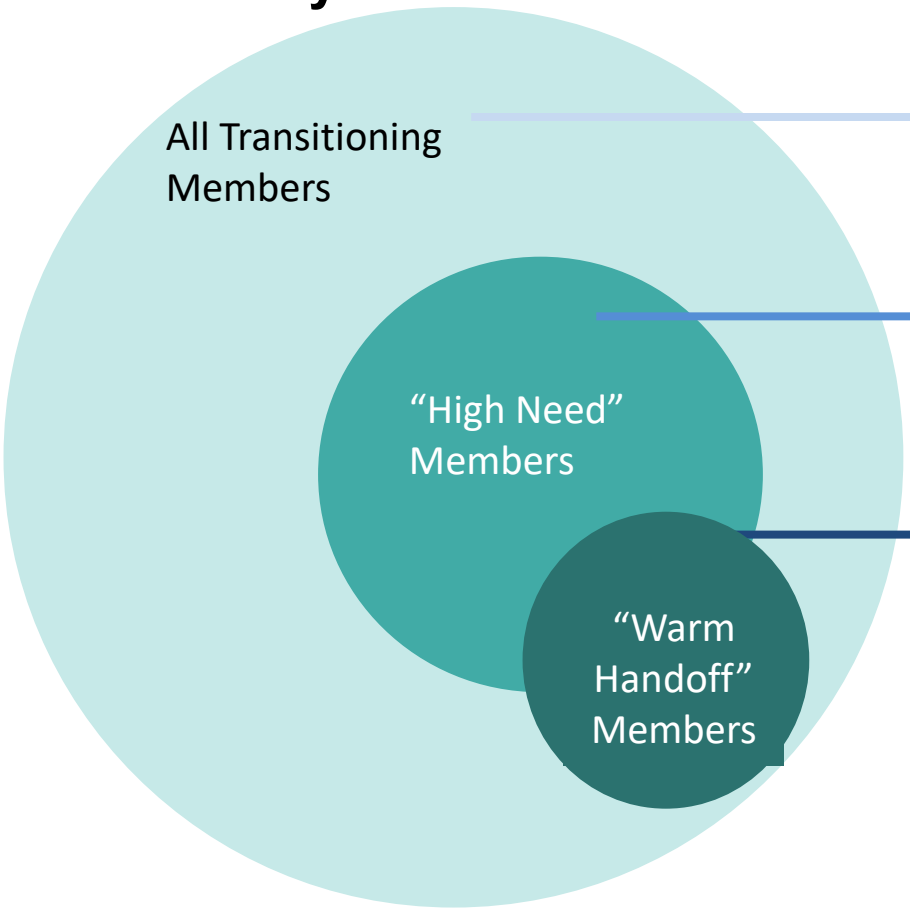
- Note: PHPs are required to treat claims for non-participating providers with dates of service on or after Standard Plan Effective Date equal to that of enrolled providers until the completion of the episode of care or 60 days, whichever is less.*

* N.C. Gen. Stat. § 58-67-88(d)-(g) still in effect.

Establishing Additional Safeguards for High Need Members

Safeguarding Beneficiary Services Through Crossover

Crossover Activities Customized Based on Service History, Vulnerability



All Transitioning Members:

Data Transfer:

- Claims
- Prior Authorization
- Pharmacy Lock In Data
- Care Plans or Assessments, if relevant

"High Need" Members:

- High Need Members are transitioning Members whose service history indicates vulnerability to service disruption
- **This group is identified on DHHS "High Need Member List"**

"Warm Handoff" Members (<2000 Members):

- High Need Members who have been identified by Medicaid Direct "transition entities" (CCNC/LME-MCOs) or by the Health Plan as warranting a verbal briefing between transition entity and Health Plan
- This group is identified on the DHHS "High Need Member List" and through a specific warm handoff/summary sheet process.

Additional Safeguards for High Need Transitioning Members

- **"High Need Transitioning Members" are beneficiaries requiring time-sensitive, Member-specific follow up by Health Plans during Crossover.**
- **DHHS will send Health Plans a list of these High Need Beneficiaries twice in June.**

High Need Members Include:

- Members receiving in-home LTSS;
- Members receiving crisis behavioral health services within 6 months of Managed Care Launch;
- Members with Inborn Errors of Metabolism;
- Members identified by CCNC, an LME-MCO, or the Department who have complex treatment circumstances or multiple service interventions and require a Warm Handoff;
- Members who are experiencing a care transition from a High Level Clinical Setting;
- Identified Standard Plan exempt members who elected to enroll in Standard Plan;
- Members authorized for transplantation;
- Members authorized for out of state services;
- Other high need Members or group of Members identified by the Department or the Health Plan.

Required Follow Up

- Direct contact with the identified Member/authorized representative to:
  - Confirm continuity of services;
  - Provide Health Plan contact information directly to Member/authorized representative;
  - Address any Crossover-related issues the Member may be experiencing.
- Health Plans must prioritize follow up activity with High Need Members based on urgency of need but should strive to conduct follow up with all identified High Need Members **no later than three weeks following Managed Care Launch.**

Establishing Additional Safeguards for High Need Members: What Providers Need to Know

- High Need Identification and Warm Handoff process occurs between LME/MCO and PHP.
  - In most cases, no provider impact.
  - If a member has been identified by the LME/MCO for “a warm handoff” and is impacted by 42 CFR Part 2, LME/MCO will likely request assistance in securing a consent.

Supporting Continuity of Care through Data Transfer

Data Transfer at Crossover: Key Data *

Claims and Encounter	• 24 months of paid and denied claims/encounter history for all services*
Open and Recently Closed Prior Authorizations (PAs)	• Open and recently closed PAs (closed within past 60 days)*
Identified Information to Support Care Management	• Care Plans from CCNC and identified LME/MCO members receiving care coordination. • PCS Assessments from PCS Vendor. • Transition Summary Sheets for Transitioning LME/MCO Members Requiring a Warm Handoff.

* Subject to 42 CFR Part 2 restrictions

Data Transfer at Crossover: LME/MCO Provider Impact

Claims and Encounter	• **Provider Impact:** None anticipated. • Data will be transferred by NC TRACKS

Open and Recently Closed Prior Authorizations (PAs)	• **Provider Impact**:
	  • If provider's authorization is not under the scope of 42 CFR Part 2, authorization will transfer automatically to member's Health Plan
	  • If provider's authorization is under the scope of 42 CFR Part 2, see slide "Data Impacted by 42 CFR Part 2"

Warm Handoff Transition Summary	• **Provider Impact:** LME/MCO may ask provider for supplemental detail to complete warm handoff Transition Summary sheet. • **Provider Impact:** Identified SUD providers will be asked to assist in requesting consent for members identified for a warm handoff.

Data Transfer at Crossover: Provider Impact

Data Impacted by 42 CFR Part 2

- *Title 42 of the Code of Federal Regulations (CFR) Part 2: Confidentiality of Substance Use Disorder Patient Records (Part 2) was promulgated… address concerns about the potential use of Substance Use Disorder (SUD) information in non-treatment based settings… Part 2 protects the confidentiality of SUD patient records by restricting the circumstances under which Part 2 Programs or other lawful holders can disclose such records.* For more information: https://www.samhsa.gov/sites/default/files/does-part2-apply.pdf
- Part 2 provider/member data, such as prior authorizations and care plans can only be transferred from the LME-MCO to the PHPs with express consent from the member; otherwise the data must be removed. This means if a provider serves a member or provides a service under 42 CFR Part 2, the authorization **will not** transfer.

Streamlining Impacted Providers Access to Post MCL Prior Authorization Protections

- Providers with open LME/MCO service authorizations for the services below or for members under the scope of 42 CFR Part 2 will submit Notice of Authorized Services to the Member's Health Plan.
- These authorizations will be treated as if they were transferred through data file transfer.

Targeted Services:

- Outpatient opioid treatment
- Ambulatory detoxification
- Non-hospital medical detoxification
- Medically supervised or alcohol drug abuse treatment center (ADATC)
- Detoxification crisis stabilization

Please join dedicated training on this process by attending either of these sessions (will repeat, do not need to attend both):

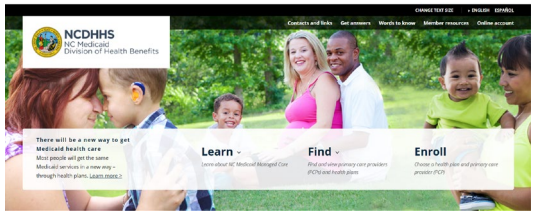
Monday, May 24, 2021—noon to 1:00pm
https://attendee.gotowebinar.com/register/3573202098353059853
Monday, June 7, 2021: noon-1:00pm
https://register.gotowebinar.com/register/8020572701079118093

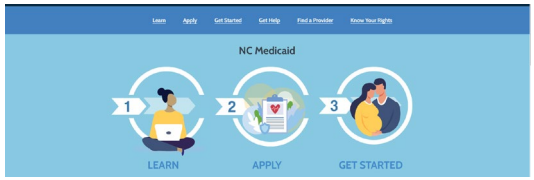
Member and Provider Education

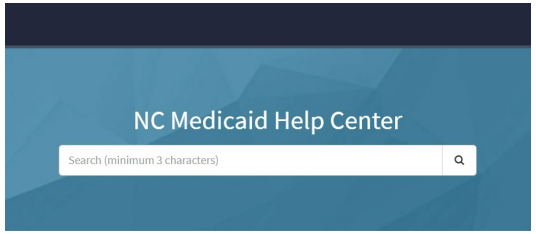
Member and Provider Education

Crossover: Integration into Broader Education Efforts

- Enrollment Broker at: ncmedicaidplans.gov
- NC Medicaid Beneficiary Portal
- NC Medicaid Help Center
- NCDHHS Transformation website (Including County & Provider Playbooks)
- Health Plan websites, handbooks and call center scripts







Member Education:
Non Emergency Medical Transportation (NEMT)

- At launch, PHPs will assume responsibility for NEMT for enrolled members.
- Currently, DSSs are working with the PHPs to inform of member appointment schedules and additional considerations for high need members.
- Enrolled members will be able to reserve post MCL appointments 1 month **PRIOR** to their effective date.

Provider Note:
Providers can help educate members about this option.

Member Education

- **Ways Providers Can Help:**
  - Help members understand their options by providing them with the Enrollment Broker contact information.
  - Finalize outstanding contracting activity with PHPs so that members are clear on which PHPs.

Member and Provider Education

Crossover: Development of Transition of Care-Specific Resources

NC DHB » Transformation » Care Management » Transition of Care

Transition of Care

The North Carolina Department of Health and Human Services (DHHS) developed policies and procedures for Transition of Care to support beneficiaries who transition between Medicaid Direct (fee-for-service) and Medicaid Managed Care delivery systems. The Transition of Care design intends to maintain continuity of care for each beneficiary and minimize the burden on providers during transition.

https://medicaid.ncdhhs.gov/transformation/care-management/transition-care

Live and under continued development

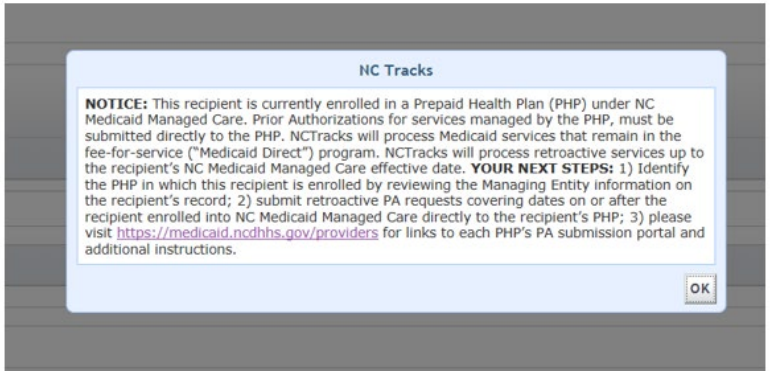
NC DHHS Transition of Care Website:

- Transition of Care Policy
- Transition of Care Technical Specifications
- PHP-specific Crossover Specific Guidance about Prior Authorization submission
- General and PHP-specific Crossover Guidance to Members about “who to call.”
- Disenrollment Protocols, as communicated on Transition of Care Policy.
- Other materials as identified.
- Links to other

Member and Provider Education

Crossover: Support to Providers Submitting PAs

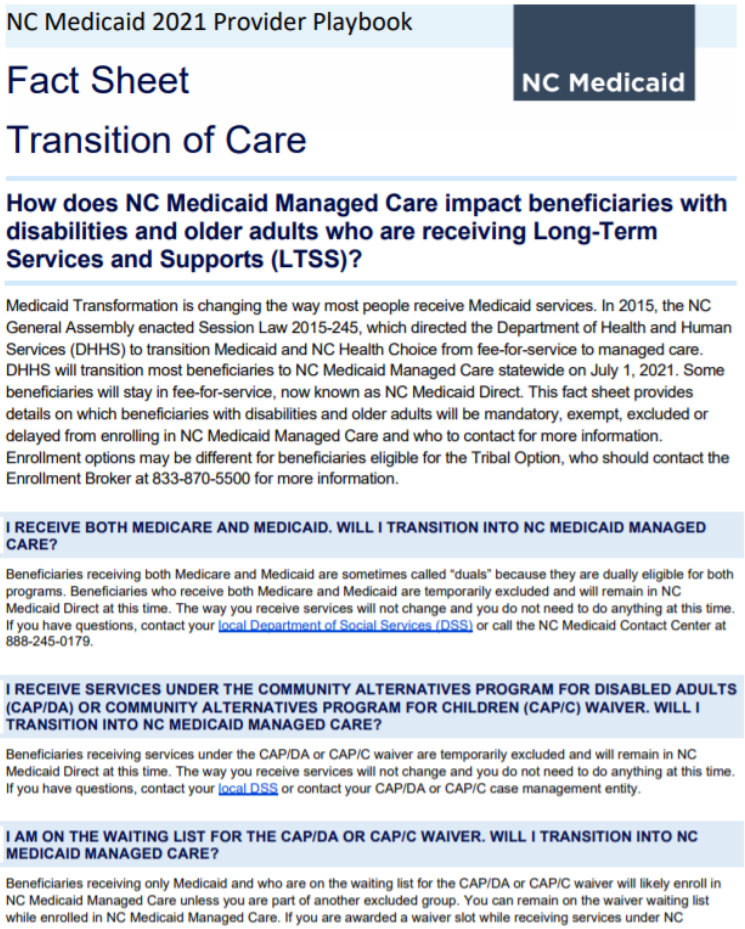
- Prior to MCL, providers will be able to see a beneficiary's upcoming Managed Care Status and PHP Assignment in NC Tracks.
  - Function in development.
  - To be in effect June, 2021
- UM Vendors including NCTracks will have provider portal messages that direct providers to PHP if applicable.
- PHP-specific PA submission instructions will be available on NC DHHS Transition of Care website.



Member and Provider Education

Crossover: Member-Facing Education/Supports

- Partnering with other Member support initiatives to develop member education tools including:
  - Call center scripts
  - Plan-specific “who to call” information
  - Transition of Care Fact Sheet for Beneficiaries who use LTSS services



NC Medicaid 2021 Provider Playbook

NC Medicaid

Fact Sheet

Transition of Care

How does NC Medicaid Managed Care impact beneficiaries with disabilities and older adults who are receiving Long-Term Services and Supports (LTSS)?

Medicaid Transformation is changing the way most people receive Medicaid services. In 2015, the NC General Assembly enacted Session Law 2015-245, which directed the Department of Health and Human Services (DHHS) to transition Medicaid and NC Health Choice from fee-for-service to managed care. DHHS will transition most beneficiaries to NC Medicaid Managed Care statewide on July 1, 2021. Some beneficiaries will stay in fee-for-service, now known as NC Medicaid Direct. This fact sheet provides details on which beneficiaries with disabilities and older adults will be mandatory, exempt, excluded or delayed from enrolling in NC Medicaid Managed Care and who to contact for more information. Enrollment options may be different for beneficiaries eligible for the Tribal Option, who should contact the Enrollment Broker at 833-870-5500 for more information.

I RECEIVE BOTH MEDICARE AND MEDICAID. WILL I TRANSITION INTO NC MEDICAID MANAGED CARE?

Beneficiaries receiving both Medicare and Medicaid are sometimes called “duals” because they are dually eligible for both programs. Beneficiaries who receive both Medicare and Medicaid are temporarily excluded and will remain in NC Medicaid Direct at this time. The way you receive services will not change and you do not need to do anything at this time. If you have questions, contact your local Department of Social Services (DSS) or call the NC Medicaid Contact Center at 888-245-0179.

I RECEIVE SERVICES UNDER THE COMMUNITY ALTERNATIVES PROGRAM FOR DISABLED ADULTS (CAP/DA) OR COMMUNITY ALTERNATIVES PROGRAM FOR CHILDREN (CAP/C) WAIVER. WILL I TRANSITION INTO NC MEDICAID MANAGED CARE?

Beneficiaries receiving services under the CAP/DA or CAP/C waiver are temporarily excluded and will remain in NC Medicaid Direct at this time. The way you receive services will not change and you do not need to do anything at this time. If you have questions, contact your local DSS or contact your CAP/DA or CAP/C case management entity.

I AM ON THE WAITING LIST FOR THE CAP/DA OR CAP/C WAIVER. WILL I TRANSITION INTO NC MEDICAID MANAGED CARE?

Beneficiaries receiving only Medicaid and who are on the waiting list for the CAP/DA or CAP/C waiver will likely enroll in NC Medicaid Managed Care unless you are part of another excluded group. You can remain on the waiver waiting list while enrolled in NC Medicaid Managed Care. If you are awarded a waiver slot while receiving services under NC

NC MEDICAID PROVIDER PLAYBOOK
Bookmark this Page:
https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care

Member and Provider Education

Provider Playbook Fact Sheet Executive Summary

NC Medicaid Managed Care has a Provider Playbook with over 20 fact sheets covering a wide range of topics providers want to know more about. Fact sheets are continuously released to keep providers up-to-date with changes that impact them and beneficiaries:

- Medicaid Transformation Overview, Enrollment, and Timelines
- What Providers Need to Know **Before** and **After** Launch
- Health Plan Quick Reference Guides
- EBCI Tribal Option Overview
- Auto Enrollment / Auto Assignment
- Newborn Policy
- Advanced Medical Homes
- Claims and Prior Authorizations
- Provider Payment
- Transition of Care
- Telehealth
- Overview of Provider Directory Data Flow
- Health Equity Enhanced Payment Initiative
- Early Intervention Services in Medicaid Managed Care

These fact sheets and more can be found at: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/fact-sheets

Post-MCL: What Happens if I Get a Referral from a Member Who is enrolled in Standard Plan but is requesting an LME/MCO-Only service?

July 1, 2021: LAUNCH	Post Launch

- NC Medicaid is modifying its current “Request to Stay”* process to a “Transition Request” Process.
- Under this updated Process, members or providers (with member consent) will be able to submit requests for the member transition to the LME/MCO.
- Approved transition requests will result in the member’s expedited transition back to the LME/MCO.
- If the transition request involves an LME/MCO-only service requiring a Service Authorization Request, (a “Service Associated Request” submission), the provider will submit a Service Associated Request Form with a Service Authorization Request.

- *Request to Stay* process is currently in effect and enables beneficiaries to request to remain in the LME/MCO. Current Forms can be found at: https://ncmedicaidplans.gov/member-resources

Questions about Today's Session?

provider.info@vayahealth.com