NC Medicaid Managed Care
County Playbook

NC Medicaid

Fact Sheet
NC Medicaid Managed Care/Nursing Facility - PHP Process

What PHPs need to know about Nursing Facility Placements

NC Medicaid applicants and members who meet nursing facility level of care and long-term care financial eligibility (including transfer of assets) based on the nursing facility (NF) level of care criteria are eligible for Medicaid NF services. Under NC Medicaid Managed Care, the level of care is approved by the member's assigned Prepaid Health Plan (PHP). Long-term care financial eligibility is approved by local Departments of Social Services (DSS).

WHAT IS THE NURSING FACILITY PLACEMENT PROCESS

PHPs will receive a nursing facility prior approval request from the NF provider. The PHP determines, per contract requirements, if the individual meets the level of care for nursing facility placement.

Nursing Facility Approval Process for PHP Members:

- Nursing facility submits prior autorization request to the PHP
- PHP approves the prior authorization request and sends to the Nursing Facility along with the PHP Notification of Nursing Facility Level of Care Form (NC Medicaid-2039)
- Nursing Facility sends the completed "PHP Notification of Nursing Facility Level of Care" form to DSS
- DSS determines long-term care financial eligibility for nursing facility care and authorizes coverage in NC FAST
  - DSS sends appropriate notice to the member
  - 834 file is updated with the patient monthly liability (PML)
- DSS sends "DHB-5016 Notification of Eligibility for Medicaid / Amount and Effective Date as the Patient's Liability" form to the nursing facility
- NF bills the PHP for NF services until disenrollment from the PHP
- PHP receives the PML on the 834 file and pays for the NF services (minus the PML)

NOTE: If the individual is found ineligible for financial eligibility for NF care – the PHP will deny the claims for NFs.

AFTER RECEIVING THE NURSING FACILITY PRIOR AUTHORIZATION REQUEST FROM A PROVIDER, WHAT DO PLANS DO IF THE MEMBER MEETS NURSING FACILITY LEVEL OF CARE?

If the member meets the nursing facility level of care and is admitted to the nursing facility, the PHP includes the member on the "MEM009 Change in Circumstance Report" and sends the approved "Prior Approval Request" and the "PHP Notification of Nursing Facility Level of Care" forms to the nursing facility. The form documents NF level of care approval by the PHP.

Important items to note when filling out MEM009:

- PHPs are required to include the nursing facility name and address of the facility where the member resides on the MEM009 in the "Other" field.
- PHPs are required to include hospital admissions on the MEM009 report as applicable.
- PHPs are required to update the MEM009 with the new facility discharge date and the new placement (i.e., home, hospital, etc.).
- Hospital admission and discharge information is required on the MEM009 as DSS needs this information for the long-term care financial eligilbilty determination process.

AFTER RECEIVING THE NURSING FACILITY PRIOR APPROVAL REQUEST FROM A PROVIDER, WHAT DO PLANS DO IF THE MEMBER DOES NOT MEET NURSING FACILITY LEVEL OF CARE?

If the member does not meet nursing facility level of care, the PHP sends the denial (including appeal rights) to the member/authorized representative and works with the member/authorized representative to identify alternative placement.

WHEN DO PLANS PAY THE NURSING FACILITY IF DSS DETERMINES THE MEMBER IS FINANCIALLY ELIGIBLE?

After DSS:

- Receives the "PHP Notification of Nursing Facility Level of Care" form documenting nursing facility level of care approval
- Determines the member meets long-term care financial eligibility
- Establishes the member's monthly liability (PML), then the PML is added to the 834 file, which is sent to the PHP daily

Once the PHP receives the 834 file confirming the PML, the PHP pays the nursing facility for the bendficiary's stay minus the PML.

WHAT DO PLANS NEED TO DO IF DSS DETERMINES THE MEMBER IS NOT FINANCIALLY ELEGIBLE?

After DSS sends the denial notification to the member/authorized representative and the State, the State will notify the PHP of the denial. Once notified, the PHP will work with the nursing facility to find alternative placement / services.

DISENROLLMNENT OF MEMBERS TO NC MEDICAID DIRECT AFTER 90 CONSECUTIVE DAYS IN A NURSING FACILITY

After 90 consecutive days in a nursing facility, the member is disenrolled from NC Medicaid Managed Care to NC Medicaid Direct on the first day of the month following the 90th consecutive day in the nursing facility.

For example, if a member enters a NF on May 21, 2022, the 90th consecutive day would be Aug. 18, 2022. Disenrollment from NC Medicaid Managed Care for the member would occur on Sept. 1, 2022.

As another example, if a member enters a NF on May 2, 2022, the 90th consecutive day would be July 21, 2022. Disenrollment from NC Medicaid Managed Care for the member would occur on Aug. 1, 2022.

WHAT SHOULD PLANS DO IF THEY DO NOT RECEIVE CONFIRMATION OF THE MEMBER'S DISENROLLMENT BY THE MONTH AFTER THE 90TH DAY?

PHPs should add the member to MEM011. After the 120th day, the plan can enter a Help Center ticket to escalate review by the State.

WHAT DO PLANS NEED TO DO WHEN A MEMBER DISENROLLS FROM NC MEDICAID MANAGED CARE TO NC MEDICAD DIRECT DUE TO A NURSING HOME FACILITY ADMISSION TLONGER THAN 90 CONSECUTIVE DAYS

Prior to the member's disenrollment, the PHP should send the Long-Term Services and Supports disenrollment form and information to medicaid.ltss.tcc@dhhs.nc.gov for transition of care.