NC Medicaid │Personal Care Services

Personal Care Services Stakeholder Meeting │July 26, 2022

Informal Meeting Notes

1. Welcome
2. Agenda
3. Introductions
4. Stakeholders Feedback

a. **Question:** brooke@sembracare.com – What percent of manual edits are considered within reason? we say 0% manual, but know some occur...do you have any parameters you could share?

Answer: provided by EVV - DHB is still reviewing the manual visit entry data and is not prepared to provide a target percentage at this time. Providers are encouraged to review their processes and reduce manual entries whenever possible. More information will be available in the near future.

b. **Question:** daniellec@mytahome.com – As for the OCPI project - is this related to the April 2022 internal audit by the PCS Program or is this a separate audit, what other items besides 3136 forms and compliance with supervisory visits as well as aide training are being reviewed? I think that I heard Patrick say something regarding service plans, but I was having difficulty hearing him fully.

Answer: provided by OCPI - Yes. We plan to expand the Audit. OCPI PCS Project will include
1.) service authorizations and approvals in accordance with Policy,
2.) service documentation to support the claims paid,
3.) licensing, training, and credentialing requirements
4.) Required components of the service and
5.) Documentation supports services appropriate for the beneficiary needs.
The review will be much more comprehensive but not all inclusive for those providers with findings during the April 2022.

c. **Question:** daniellec@mytahome.com – Can you provide some more details regarding the outcome of the internal audits that were completed in April? How many beneficiaries were sampled (# of IH and # of ACH)? What % were found to be in compliance? Were there any providers that did not respond to the record request?

Answer provided by PCS – The unit reviewed a total of 100 providers (50 ACH/50 IHC).16 providers were not responsive, 40 were in compliance, and 44 are under review for recommendations. The compliance rate increased by 9% from the last audit.

d. **Question:** shinne@tlcathome.org – We have had 2 beneficiaries transition from Managed care (one from United Healthcare and one from healthy Blue). Neither of these Health plans notified the beneficiary or our agency of the disenrollment from Managed Care, therefore both beneficiaries were dropped off of their plan with no prior planning to make sure no gap in coverage. We have emailed someone at PCS dept but think you all should be aware that Managed Care plans are dropping the ball on this Transition of Care to the point that the Case Managers, etc. don't even know that there is a transition of care protocol. This should be looked into on the Managed Care side.

Answer provided by TOC - The NCDHHS Transitions of Care Policy, in section D.1 c (2) "Additional Requirements for Members Disenrolling from PHP to NC Medicaid Direct (including LME/MCOs) or Tribal Option" states PHPs are required to coordinate "with entities necessary to ensure Member continuity of care upon disenrollment, including but not limited to: .... (2) Informing the Member's current Medicaid providers of the anticipated disenrollment."
Communication about this requirement will be sent to the PHPs.

e. **Question:** toms@algsenior.com – If a beneficiary moves back to Medicaid Direct, and the PA's transfer, how long are the authorizations good for before a new assessment is required? Will a new 3051 be needed or will they go into cue for an annual?

Answer provided by TOC - Prior approvals found in NC Tracks have effective begin and end dates. This is true whether the PA was originally generated through Liberty/NC Tracks or through a PHP. Those PAs can be used to adjudicate claims for dates of service when the beneficiary is in Medicaid Direct in alignment with the effective dates on the PA. A new 3051 needs to be sent to Liberty to "stitch" the beneficiary back into the process. Liberty needs the 3051 to review current PAs and last assessment date to determine if a new assessment and additional PAs are needed.

f. **Question:** amanda_w_taylor@uhc.com – We have seen a number of voided members that tickets have been entered on. For example, we have seen several members who acquired Medicare on 7/1/22 but ALL of their coverage has been voided. These members are actually voided, not technically retro disenrolled. Has there been any reason found that we are seeing these voids?

Answer provided by TOC - A specific root cause has not been identified but it appears to be tied back to a lack of Medicare evidence in NC Tracks. The Member group is working on this with the DSS.

g. **Question:** amanda_w_taylor@uhc.com - Re: retro disenrollment's - what if they are brought back to 7/1/2021 retroactive. How does this affect timely filing of 365 days?

Answer provided by TOC - For claims in Medicaid Direct, if a provider has an issue with the 365-day edit, they should call the Ombudsman and a ticket will be generated. A NC Tracks ticket will be submitted by the TOC team.

h. **Question:** dan.demirgian@gmail.com - When will the tailored plans reach out to provided to register them into their networks?

Answer provided by TOC - Providers should proactively reach out and enroll with the Tailored Plans with which they wish to contract. It is recommended that providers review the NC Medicaid website for information on contracting with Tailored Plans. NC Medicaid Managed Care: Contracting with Tailored Plans https://medicaid.ncdhhs.gov/media/11452/open

i. **Question:** heather.wilman@wellcare.com - When a member transitions from a PHP to Medicaid Direct and they have PCS in place are there any transition plans to allow services to remain in place for 90 days? Similar to our TOC process with go live?
Answer provided by TOC - The continuity of care process is fostered by the transition of prior approvals between entities to allow services to remain in place without disruption. The receiving entity is to honor approved PAs received.

j. **Question:** londonspot2@yahoo.com - Is there any internal discussion and or consideration on the severe shortage of CNA's and the impact agencies are experiencing staffing clients?

Answer: The Division is aware of the staffing issues and are monitoring trends.

k. **Question:** amanda_w_taylor@uhc.com - Just to understand the process, is a new assessment completed by Liberty at the time of transition as well OR is a new assessment done at the time of reauthorization?

Answer provided by PCS - A DHB 3051 Request Form should be submitted within 30 days of the date of disenrollment from their PHP. The form should be submitted to the PCS IAE (currently Liberty Healthcare of NC). Once the DHB 3051 is received and reviewed, if correct and complete it is entered into QI Report. A determination as to whether a new assessment is needed will be made on a case-by-case basis to most appropriately service the beneficiary.

l. **Question:** brooke@sembracare.com – Do you have an estimate of how many PCS members may be Tailored Plan members come Dec?

Answer provided by TOC – This information will be shared at the next stakeholders meeting.