NC Medicaid Managed Care
County Playbook

NC Medicaid

Fact Sheet

How to Change NC Medicaid Managed Care Plans with the Enrollment Broker

How can NC Medicaid Managed Care members change health plans?

To request a change in a health plan, the member or authorized representative must contact the NC Medicaid Enrollment Broker. If you change your health plan, the change will be effective on the first day of the following month.

The Enrollment Broker is an unbiased third-party entity that provides managed care choice counseling and enrollment assistance to members.

For assistance, members or their authorized representative can go to Enrollment Broker website at ncmedicaidplans.gov. Members, or their authorized representative, can call the Enrollment Broker toll free at **1-833-870-5500** (TTY: 711 or RelayNC.com), 7 a.m. to 7 p.m., Monday through Friday. Members may need their Medicaid ID number when they call or go to the website.

HOW TO CHANGE A HEALTH PLAN

Below are the types of requests available to change a health plan.

	"Without Cause" **Standard Plan** Change Request	"With Cause" **Standard Plan** Change Request	Request to Move to a **Tailored Plan**	Request to Leave the **Children and Families Specialty Plan**
Change request description	Request made for any reason Approval not required	Request made for a special reason Approval required	Request made when needed services are only offered by a Tailored Plan Approval required	Request made when needed services are not offered by the Children and Families Specialty Plan Approval required

	"Without Cause" **Standard Plan** Change Request	"With Cause" **Standard Plan** Change Request	Request to Move to a **Tailored Plan**	Request to Leave the **Children and Families Specialty Plan**
When the request is used	During the annual 90-day choice period or after a health plan change	Outside the annual 90-day choice period	At any time	At any time
Who submits the request	Member or authorized representative	Member or authorized representative	Member, authorized representative, provider, care manager	Member or authorized representative
When the request becomes effective	First day of the following month	First day of the following month	**Non-service Associated Request**: First day of the following month **Service-associated Request**: Retroactive to the date of the request	First day of the following month
Informed Consent required?	No	No	No	Yes

HOW TO CHANGE A STANDARD PLAN

Within the first 90 days of enrollment, Standard Plan members can change their health plan for any reason. This is called the "90-day choice period." Members have an additional 90-day choice period once a year, and again immediately after they have changed health plans.

Members will receive a notice from the Enrollment Broker to tell them when their annual choice period is. Standard Plan members can change their health plan at any time if they have a "with cause" reason, such as:

- Member moved out of their health plan's service area
- Have a family member in a different health plan
- They cannot get all the related services they need from providers in their health plan and there is a risk of getting the services separately
- A different health plan may be better for their complex medical conditions
- Their Long Term Services and Supports (LTSS) provider is not in their health plan
- Health plan does not cover a service they need for moral or religious reasons

- Other reasons (poor quality of care, lack of access to services covered, lack of access to providers experienced in dealing with their health care needs)

REQUEST TO MOVE TO A TAILORED PLAN

Tailored Plans, Standard Plans and the Children and Families Specialty Plan (CFSP) offer the same physical health services.

Tailored Plans and the CFSP offer additional services for a serious mental health disorder, severe substance use disorder and Intellectual/Developmental Disability (I/DD) or traumatic brain injury. The CFSP provides statewide services and supports, while the Tailored Plan services are limited to the counties each Tailored Plan covers.

To enroll in a Tailored Plan, members or their providers can fill out a **Request to Move form** with the Enrollment Broker.*

The "Request to Move to Tailored Plan: Provider Form" and the "Request to Move to Tailored Plan: Beneficiary Form" can be found and submitted online at ncmedicaidplans.gov/submit-forms-online.

Forms can also be mailed or faxed. For a printable form, call the Enrollment Broker at 1-833-870-5500 (TTY: 711 or RelayNC.com).

The provider form can be completed for the member by a doctor, therapist or other I/DD, mental health or substance use disorder provider. The form can be used for two types of submissions, Service-associated Requests and Nonservice-associated Requests. Service-associated Requests require a Service Authorization Request (SAR) and can be found in step three of the form.

Providers should only submit Nonservice-associated Requests to request to move CFSP beneficiaries to a Tailored Plan. SARs are not required for members disenrolling from the CFSP and moving to a Tailored Plan. SARs that are submitted to request CFSP beneficiaries move to a Tailored Plan will be processed as a Nonservice-Associated Request.

The beneficiary form can be filled out by the member or their legally responsible person such as the head of household, legal guardian or authorized representative. This form can be used for a Nonservice-associated Request submission. This form may also be used to request to move CFSP beneficiaries to a Tailored Plan.

See below for more information on Service-associated and Nonservice-associated Requests.

	Service-associated Request	**Nonservice-associated Request**
Who can submit requests?	Provider	Member (or their authorized representative, legal guardian), provider
Processing time	Within one business day	Five business days for provider forms Eight business days for beneficiary forms
When does the member move to Tailored Plan?	The day the request is submitted	After approval, the member is enrolled the first day of the following month

If approved, members will receive a notice from the Enrollment Broker. The notice will tell the member when the move to Tailored Plan is effective (either the first day of the following month or the date the request was submitted).

If denied, the Enrollment Broker will send the member a denial letter which includes information on the beneficiary's right to appeal the decision and the reason for the denial. The member has 30 days from the date of the denial notice to request a State Fair Hearing (appeal).

To learn more about how to complete the request, view an informational video at ncmedicaidplans.gov/submit-forms-online.

To read the fact sheet on Request to Move to a Tailored Plan, visit this webpage Fact Sheet NC Medicaid Managed Care: Request to Move to Tailored Plan.

* EBCI Tribal Option members and members in the Children and Family Specialty Plan do not have to complete a request to move if they have Tailored Plan as a choice. To learn what choices the members have, they should read the Health Plan Option Guide included in their enrollment packet they got in the mail or call the Enrollment Broker toll free at **1-833-870-5500** (TTY: 711 or RelayNC.com), 7 a.m. to 7 p.m., Monday through Friday.

INFORMED CONSENT – DISENROLLING FROM THE CHILDREN AND FAMILIES SPECIALTY PLAN OR A TAILORED PLAN

Members or their authorized representative need to confirm their choice verbally with the Enrollment Broker before disenrolling from the Children and Families Specialty Plan or a Tailored Plan. This is called informed consent.

Members, or their authorized representative, must call the Enrollment Broker toll free at **1-833-870-5500** (TTY: 711 or RelayNC.com), 7 a.m. to 7 p.m., Monday through Friday before they can move to a Standard Plan.

The Enrollment Broker will explain their health care options so members or their authorized representative can make the best choice for the member's individual needs.

If the enrollment form is faxed or mailed to the Enrollment Broker, the Enrollment Broker will call to explain the available health plan options. Before a member is enrolled in a Standard Plan, they or their authorized representative must confirm the choice.

If the Enrollment Broker cannot reach the member or their authorized representative after three tries, they will deny the request to move to a Standard Plan or Tailored Plan (if applicable). If the member or their authorized representative disagrees with the denial, they can appeal by asking for a State Fair Hearing (appeal).

HOW EBCI TRIBAL OPTION MEMBERS CAN CHANGE HEALTH PLANS

EBCI Tribal Option members are not required to be in a NC Medicaid Managed Care health plan. They can move freely between health care options at any time.

EBCI Tribal Option members will not be auto-enrolled into NC Medicaid Managed Care and can choose the health care option that best suits their needs. To change their health care option, EBCI Tribal Option members can:

- Call the Enrollment Broker toll free at **1-833-870-5500** (TTY: 711 or RelayNC.com), 7 a.m. to 7 p.m., Monday through Friday
- Mail or fax an Enrollment Form to the Enrollment Broker
- Go to the Enrollment Broker's website at ncmedicaidplans.gov.