Fact Sheet
NC Medicaid Managed Care/Nursing Facility – Health Plan Process

What Health Plans Need to Know About Nursing Facility Placements

NC Medicaid 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 health plan. Long-term care financial eligibility is approved by local Departments of Social Services (DSS).

WHAT IS THE NURSING FACILITY PLACEMENT PROCESS

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

Nursing Facility Approval Process for Health Plan Members:

- Nursing facility submits prior authorization request to the health plan
- Health plan approves the prior authorization request and sends to the Nursing Facility along with the Prepaid Health Plan (PHP) Notification of Nursing Facility Level of Care Form (DHB-2039)
- Nursing Facility sends the completed "PHP Notification of Nursing Facility Level of Care (DHB-2039)" form to DSS
- DSS enters the patient monthly liability (PML) for non-Modified Adjusted Gross Income (non-MAGI) members. Effective Sept. 1, 2025, DSS will no longer enter PML values for MAGI members.
    - 834 file is updated with the patient monthly liability (PML) for non-MAGI members
- NF bills the health plans for NF services until disenrollment from the health plans
- Health plan receives the PML on the 834 file for Non-MAGI members and pays for the NF services (minus the PML)
- DSS determines long-term care financial eligibility for nursing facility care and authorizes coverage in NC FAST
    - DSS sends appropriate notice to the member
- DSS sends "Notification of Eligibility for Medicaid / Amount and Effective Date as the Patient's Liability (DHB-5016)" form to the nursing facility

- If the individual is found ineligible for financial eligibility for NF cost of care, NC Medicaid will send the DSS-8110 “Your Medical Assistance Benefits Are Continuing, Changing, or Terminating” notice to the health plan. Based on when the change is effective, the health plan will terminate NF cost of care payments effective the date indicated on the DSS-8110 notice. This termination date for NF cost of care will always be the last day of the month.

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 health plan 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 (DHB-2039)” forms to the nursing facility. The form documents NF level of care approval by the health plan.

Important items to note when filling out MEM009:

- Health plans are required to include the nursing facility name and address of the facility where the member resides on the MEM009 in the “Other” field.
- Health plans are required to include hospital admissions on the MEM009 report as applicable.
- Health plans are required to update the MEM009 with the new facility discharge date and the new placement (i.e., home, hospital).
- 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 health plan 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?

For MAGI members, health plans can pay nursing facility claims after the plan reviews the prior authorization, confirms the member meets nursing facility level of care and sends the “PHP Notification of Nursing Facility Level of Care (DHB-2039)” form to the Nursing Facility.

For non-MAGI members, once the health plan receives the 834 file confirming the PML, the health plan should pay the nursing facility for the beneficiary’s stay minus the PML.

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

After DSS sends the denial notification to the member/authorized representative and the State, the State will notify the health plan of the denial. Once notified, based on when the change is effective, the health plan will terminate NF cost of care payments effective the date indicated on the DSS-8110 notice. This termination date for NF cost of care will always be the last day of the month.

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?

Health plans 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 MEDICAID DIRECT DUE TO A NURSING HOME FACILITY ADMISSION LONGER THAN 90 CONSECUTIVE DAYS?

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