NC Medicaid Managed Care
Provider Playbook

NC Medicaid

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

How does NC Medicaid Managed Care impact providers and Nursing Facility placements?

Medicaid members who meet nursing facility (NF) level of care and long-term care financial eligibility (including transfer of assets) are eligible for Medicaid NF services. Under NC Medicaid Managed Care, the level of care is approved by the beneficiary's assigned health plan. Long-term care financial eligibility is approved by local Departments of Social Services (DSS).

WHAT SHOULD NURSING FACILITIES KNOW ABOUT THE NURSING FACILITY PLACEMENT PROCESS?

Either the admitting NF or referring agency (such as a hospital or a physician's office) can submit the Pre-Admission Screening and Resident Review (PASRR) Level I screen via the NC Medicaid Uniform Screening Tool (NCMUST) application. NCMUST is a self-service, web-based application used to manage the NC PASRR program. PASRR is a federally required screening for any individual who applies to, or resides in a Medicaid-certified nursing facility, regardless of the source of payment.

Once the PASRR authorization is obtained:

- The NF submits a prior authorization (PA) request for NF services to the member's assigned health plan.
- The NF includes the PASRR authorization number on the prior authorization request.
- If the NF prior authorization request is approved by the health plan, the health plan will provide the NF with a copy of prior authorization with a Prepaid Health Plan (PHP) Notification of Nursing Facility Level of Care (DHB-2039) form which documents NF level of care approved by the health plan.

The admitting NF is responsible for:

- Updating and submitting the "PHP Notification of Nursing Facility Level of Care" (DHB-2039) form to DSS in the county where the applicant's eligibility is maintained, within five business days of receipt.
- Once DSS is notified of the admission to the NF, DSS will begin their review of the member's long-term care financial eligibility.

DSS responsibilities include:

- Entering the patient's monthly liability (PML) for non-modified adjusted gross income (non-MAGI) members.
    - Note: Effective Sept. 1, 2025, DSS will no longer enter PML values for MAGI members who have been admitted into a nursing facility.
- Reviewing all financial assets the member has, or has had, an ownership interest within the established lookback period. This includes any assets the member sells or gives away.
- Determining whether the member transferred any assets to become financially eligible for care in the nursing facility.

The timelines for receipt of this information vary depending on the information needed.

WHAT INFORMATION IS NEEDED FROM NURSING FACILITIES FOR DSS TO DETERMINE FINANCIAL ELIGIBILITY?

The NF should submit the "PHP Notification of Nursing Facility Level of Care" (DHB-2039) form to the local DSS within five business days of receipt from the health plan. If the member was admitted to the nursing facility from the hospital, NFs are required to include that information in documentation submitted to DSS (this information is required for determination of long-term care financial eligibility).

NEXT STEPS AFTER DSS DETERMINES FINANCIAL ELEGIBILITY

DSS determination of long-term care financial eligibility is based on the following:

- Receipt of the "PHP Notification of Nursing Facility Level of Care" (DHB-2039) form from the NF with the health plans approved facility level of care.
- Review of other financial documents needed to make a long-term care financial eligibility determination for non-MAGI members.

DSS will enter the PML for non-MAGI members. Note: Effective, Sept. 1, 2025, MAGI members no longer require a PML to be entered.

For non-MAGI members, the health plan is notified via the daily 834 file transmittal that long-term care financial eligibility has been established if a beneficiary shows a PML. The health plan may pay the NF for the member's services less the amount of the PML.

Once a member's long-term care financial eligibility is approved, DSS will send a Notice of Approval to the member/authorized representative. DSS will also send a "Notification of Eligibility for Medicaid/Amount and Effective Date of Patient Liability" to the NF (DHB-5016).

DISENROLLMENT 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.

- The disenrollment is effective on the first day of the month following the 90th consecutive day in the nursing facility.

Examples:

- 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.
- 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.

Note: Members may also be disenrolled from NC Medicaid Managed Care for other reasons other than a 90-day NF stay.

NURSING FACILITY NOTIFICATION OF MEMBER DISENROLLMENT

Per the Department's Transition of Care policy, the health plan is required to inform the member's current Medicaid providers of the anticipated disenrollment. Nursing facilities should expect notification from the member's health plan when the member has disenrolled back to NC Medicaid Direct.

NURSING FACILITY RESPONSIBILITIES FOLLOWING MEMBER DISENROLLMENT

After a member has been disenrolled from NC Medicaid Managed Care to NC Medicaid Direct, the nursing facility should:

- Confirm the beneficiary has a valid (current) PASRR number.
- Submit a new nursing facility prior authorization request (FL-2) to NCTracks.
- Confirm DSS has begun the long-term care financial eligibility process by checking to see if DSS has all necessary information needed to finish the long-term care financial eligibility determination.

WHAT IF A MEMBER ISN'T DISENROLLED AFTER 90 CONSECUTIVE DAYS

If a member has not been disenrolled from NC Medicaid Managed Care the first of the month following the 90th consecutive day, the facility should contact DSS to confirm receipt of the "PHP Notification of Nursing Facility Level of Care" (DHB-2039) form and the long-term care financial eligibility determination, if applicable, is complete.

WHAT TO DO IF A MEMBER'S RETROACTIVE DISENROLLMENT IS LONGER THAN 90 DAYS

The nursing facility should contact the Medicaid Provider Ombudsman at 1-866-304-7062 or Medicaid.ProviderOmbudsman@dhhs.nc.gov to generate a ticket for the State to review, and if appropriate, request a retroactive prior authorization.

NC Medicaid has created a Provider Ombudsman to represent the interests of the provider community and to assist with general inquiries and complaints regarding Health Plans. The Ombudsman will:

- Provide resources and assist providers with issues through resolution.
- Assist providers with Health Information Exchange (HIE) inquires related to NC HealthConnex connectivity compliance and the HIE Hardship Extension process.
- The Provider Ombudsman contact information is also published in each Health Plan's provider manual.

ADDITIONAL INFORMATION

Additional resources/information is available below:

- For questions about contracting, contact the Health Plan. Contact information can be found on our website at medicaid.ncdhhs.gov/health-plans/health-plan-contacts-and-resources.
- For questions related to NCTracks provider information, contact the NCTracks Call Center at 1-800-688-6696. To update your information, please log into NCTracks (nctracks.nc.gov) provider portal to verify your information and submit a Manage Change Request or contact the Call Center.
- To view NC Medicaid Help Center Knowledge Articles medicaid.ncdhhs.gov/helpcenter. If you have questions about Medicaid Transformation, email Medicaid.transformation@dhhs.nc.gov.
- For all other questions, please contact the NC Medicaid Contact Center at 1-888-245-0179.