NC Medicaid Managed Care
Provider Playbook

Fact Sheet
Panel Management for Primary Care Providers (PCPs)

How do I select or modify my panel size?

NC Medicaid providers participating as Advanced Medical Homes (AMHs) and/or Primary Care Practices (PCPs) may select or modify their panel size during their initial enrollment application. Medicaid-enrolled providers update panel size through the Manage Change Request (MCR) process for NC Medicaid Direct members and through health plans for NC Medicaid Managed Care beneficiaries. Health plans are contractually required to allow AMHs/PCPs to set limits on panel size and have a process by which to do so.

HOW TO CHECK PATIENT ELIGIBILTY/ HEALTH PLAN ENROLLMENT

The Recipient Eligibility Verification function of NCTracks includes the beneficiary's benefit program and managed care assignment information and allows providers to verify current eligibility and eligibility for the following month. *Always verify coverage and managed care assignment prior to rendering services as prospective eligibility information may be subject to change.*

WHAT HAS CHANGED ABOUT THE NCTRACKS RECIPIENT ELIGIBILTY VERIFICATION ?

NC Medicaid Managed Care Tailored Care Management (TCM) provider information has been added to the Recipient Eligibility Verification page, if applicable. This includes health plan name, TCM provider information and contact information, as well as the health plan’s assignment for PCP/AMH. It is important for providers to give special attention to the Service Types and Copay section under each benefit plan due to carve-out services and the necessity to display other benefit plan information.

Benefit Plan	What Does it Mean?
Medicaid Managed Care – Standard Plan	Beneficiary is enrolled in NC Medicaid Managed Care. The health plan is identified along with the dates of enrollment. The Service Types and Copay section identify the services covered and billed to the beneficiary's health plan.
Medicaid Managed Care Carve-out Plan (MCCRV)	Health plans are not responsible for carved out services. The Service Types and Copay section under this benefit plan identifies carved out services, including dental, frames, lenses, and case management (for children's developmental services agency (CDSA) services), all of which would continue to be billed through Medicaid Direct - Medicaid's fee-for-service program. See the Health Plan Contracts page for more details on carved out services.
Managed Care for Behavioral Health Services (PHPB)	For Medicaid beneficiaries beginning at age three, Local Management Entities/Managed Care Organizations (LME/MCOs) provide comprehensive behavioral health services under the NC 1915(b)(c) Waiver. This benefit plan identifies the LME/MCO entity offering the Service Type identified (Mental Health - Mntl Hlth) and to which these services would be billed.
Tailored Plan Innovations Waiver Managed Care (TPINV)	Beneficiary is enrolled in NC Medicaid Managed Care (Innovations Waiver). The health plan is identified along with the dates of enrollment.
Innovations Waiver – CAP Services (PHPC)	Beneficiary is receiving Community Alternatives Program (CAP) services from the LME/MCO. The LME/MCO is identified along with the dates of enrollment.
Traumatic Brain Injury Waiver (TBI)	Beneficiary is receiving TBI services from the LME/MCO. The LME/MCO is identified along with the dates of enrollment.
Medicaid Direct	Beneficiary remains in the NC Medicaid Direct (formerly fee-for-service) program for the dates specified. The Service Types and Copay section identifies the services covered and billed through the NC Medicaid Direct program.

HOW TO UPDATE YOUR PANEL IN NCTRACKS

Providers can update their panel limitations for NC Medicaid Direct in NCTracks by logging into the Provider Portal and submitting an MCR to update their provider record. For more information, see the Enrolling, Updating or Terminating CCNC/CA Managed Care Plans User Guide. For questions related to NCTracks provider information, please contact the NCTracks Call Center at 800-688-6696.

HOW TO UPDATE YOUR PANEL WITH EACH STANDARD PLAN

Information for updating and setting panel limits with each Standard Plan is included in the table below:

AmeriHealth Caritas North Carolina (AMHC)	Panel limits would be discussed/agreed upon during contracting. Panels may be limited (in the AMHC system) by member age and number of members. Unless specified otherwise during contracting, the panel remains open unless the PCP is under sanction, has voluntarily closed their panel, or is closed by AMHC due to member access issues. AMHC requires providers to provide 90 days prior written notice to close or update panel limits. Information on updating panels can be found on AMHC's secure provider portal.
Carolina Complete Health (CCH)	If a provider wants to change their panel size, they can submit the request on letterhead to their assigned Provider Engagement Coordinator. If panel size is not specified at the point of contracting, the panel limit is set to a default number (explained during contracting) with the intent to limit the possibility of over assignment during the member auto-assignment process. More information on updating panels can be found on the CCH secure provider portal.
Healthy Blue	After submitting an MCR to NCTracks, if providers need additional assistance, please contact Healthy Blue at NC_Provder@healthybluenc.com or contact Provider Services at 844-594-5072, Monday to Saturday, 7 a.m. to 6 p.m. e.t. More information on updating panels can be found on Availity Essentials's secure provider portal. Providers will have open panels, unless otherwise requested or indicated. Healthy Blue will prepopulate its system with the NCTracks panel limits for ages and gender provided to PHPs and encourage providers to validate NCTracks before contacting Healthy Blue. After submitting panel- related Manage Change Request to NCTracks, if providers need additional assistance, please contact Healthy Blue at NC_Provider@healthybluenc.com.
WellCare (WCHP)	Providers will keep an open panel unless otherwise requested (must follow requirements for closing panel) OR panel limits may be negotiated and added to their contract. Providers are educated during a WCHP New Provider Orientation. More information on updating panels can be found on the WCHP online provider directory.
United Healthcare (UNHC)	Participating network providers may submit a request to update their panel limit to networkhelp@uhc.com Providers currently in negotiations should discuss their panel limit with the network contractor as part of the negotiation process. Additionally, any change to the accepting new patient's indicator should be updated via NCTracks as that information is ingested daily from the provider enrollment file.

DO I NEED AUTHORIZATIONS TO PROVIDE PRIMARY CARE FOR A MEMBER NOT ASSIGNED TO ME ?

Members do **NOT** need an authorization to see an in-network PCP even if that PCP is not the assigned PCP. We encourage all PCPs to help members engage with their assigned practice or help members change their assignment. Members **WILL** need a prior authorization to see a PCP who is **NOT** in network.

HOW DO I HELP A MEMBER CHANGE THEIR PRACTICE ASSIGNMENT ? HOW LONG BEFORE THE CHANGE GOES INTO EFFECT ?

Only the member may request PCP reassignment.

PCPs may encourage managed care members to call their health plan's member services phone number on the back of their Medicaid ID card to change their PCP. Members can also call the NC Medicaid Enrollment Broker at 833-870-5500 to change their PCP if they are also changing their health plan enrollment.

The member's assignment will change the first of the following month according to NC Medicaid policy. The member can still have services provided by that PCP prior to the reassignment without authorization if the PCP is in network with the health plan.

HOW DO I REMOVE MEMBERS FROM MY PANEL?

PCPs actively caring for Medicaid Direct beneficiaries assigned to their practice may help updates their practices assignment by encouraging beneficiaries to contact their local Division of Social Services (DSS) caseworker to request reassignment. Fax numbers and other contact information are available on the Local DSS Directory. In instances where issues persist or escalation is needed, beneficiaries may contact the Medicaid Contact Center at 888-245-0179 for assistance.

PCPs in Standard Plans are encouraged to use their care management resources to help members with barriers to engage. For members in managed care (Standard Plan or Tribal Option), providers should work with their health plans to assist members with barriers to engagement or to find a better PCP fit if all options have been exhausted.

STANDARD PLAN CONTACTS FOR ASSISTANCE WITH PANEL ISSUES/QUESTIONS

AmeriHealth Caritas North Carolina (AMHC)	Hazen Weber hweber@amerihealthcaritasnc.com
Carolina Complete Health (CCH)	Reach out to your assigned Provider Engagement Administrator or email Network Support Team at networkrelations@cch-network.com.
Healthy Blue	NC_Provider@healthybluenc.com (Subject line: Panel Issues)
WellCare (WCHP)	NCProviderRelations@Wellcare.com (Subject line: Panel Issues)
United Healthcare (UNHC)	Mary Galluppi mary_galluppi@uhc.com Russ Graham russ.graham@optum.com

WHAT IF I HAVE QUESTIONS?

Additional resources for providers on the transition to managed care can be found in the NC Medicaid Help Center, the Provider Playbook and on the Medicaid Transformation website.

For general provider inquiries and complaints regarding health plans, contact the **Provider Ombudsman** at Medicaid.ProviderOmbudsman@dhhs.nc.gov, or 866-304-7062. The Provider Ombudsman contact information is also published in each health plan's provider manual.

For questions related to your NCTracks provider information, please contact the NCTracks Call Center at 800-688-6696. To update your information, please log into the NCTracks provider portal to verify your information and submit a MCR.