Fact Sheet
NC Medicaid Managed Care: Request to Move to NC Medicaid Direct

What is the process to request to move to NC Medicaid Direct?

While physical health services are the same for all individuals with Medicaid, some services for members with an intellectual/developmental disability (I/DD), mental illness, traumatic brain injury (TBI) or substance use disorder are only available in NC Medicaid Direct and/or through the LME/MCOs. The Request to Move to NC Medicaid Direct process is used for members currently enrolled in a health plan with NC Medicaid Managed Care who need services only available through NC Medicaid Direct and/or through the LME/MCOs.

The Request to Move to NC Medicaid Direct (formerly fee-for-service) or LME/MCO: Beneficiary and Provider Forms can be submitted to indicate that the member has used or needs services only available through NC Medicaid Direct and/or through the LME/MCOs.

REQUEST TO MOVE TO NC MEDICAID DIRECT OR LME/MCO: PROVIDER FORM

The Request to Move to NC Medicaid Direct or LME/MCO: Provider Form can be submitted online at ncmedicaidplans.gov/submit-forms-online or by calling the Enrollment Broker at 833-870-5500 to request a downloadable version that can be mailed or faxed. The form can be filled out by a doctor, therapist or other I/DD, mental health or substance use disorder provider for the member. This form can be used for two types of submissions: Service-associated Requests and Nonservice-associated Requests.

	SERVICE-ASSOCIATED REQUESTS	NONSERVICE-ASSOCIATED REQUESTS
WHO CAN SUBMIT REQUESTS?	• The request must be submitted by a provider with the member's consent using the *Request to Move to NC Medicaid Direct or LME/MCO: Provider Form* • A Service Authorization Request (SAR) or Treatment Authorization Request (TAR) are required along with any necessary documentation. This must be submitted with the Provider Form	• The request may be submitted by a provider with the member's consent using the *Request to Move to NC Medicaid Direct or LME/MCO: Provider Form* • The request may be submitted by a member using the *Request to Move to NC Medicaid Direct or LME/MCO: Beneficiary Form*
PROCESSING TIME	• Within one business day from when the request is sent to the LME/MCO, and the individual is moved within one business day retroactive to the date of the request	• Five days for Provider Forms • Eight days for Beneficiary Forms • Upon approval of the request, the individual is enrolled in NC Medicaid Direct effective the first day of the following month

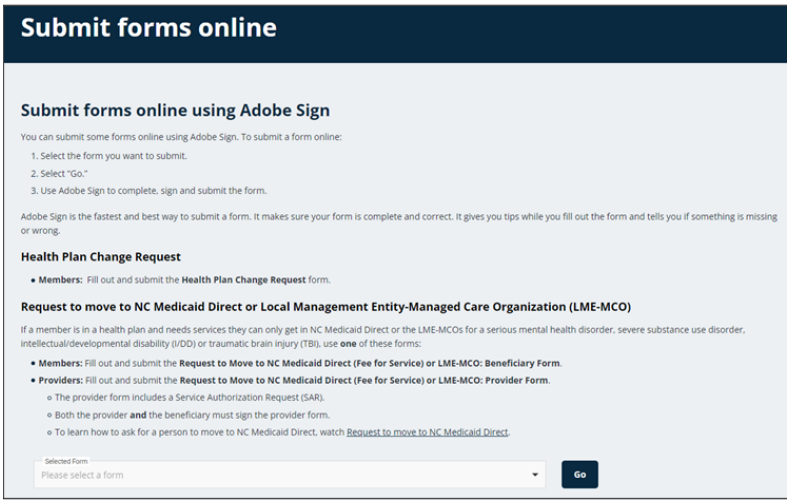
If approved, beneficiaries will receive notice from the Enrollment Broker. The notice will inform the beneficiary the move to NC Medicaid Direct is effective either the first day of the following month or on the date the Service-associated Request was submitted. If the beneficiary is denied, Medicaid will send the beneficairy a denial letter

which includes information on the beneficiary's right to appeal the decision and the denial reason. The beneficiary has 30 days from the date of the denial notice to request a State Fair Hearing (appeal).

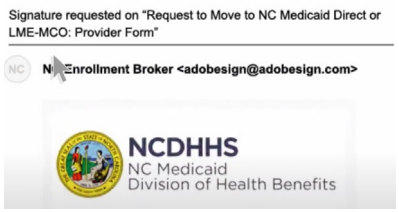
A video outlining how to submit requests is available online at ncmedicaidplans.gov/submit-forms-online.

TO SUBMIT A SECURE REQUEST ONLINE

1. Go to ncmedicaidplans.gov/submit-forms-online and select the "Request to Move to NC Medicaid Direct or LME/MCO: Provider Form" from the drop-down menu.



2. Complete the required fields.
3. On page 10 of the form is the Service Authorization Request (SAR) form. This can be filled out or a SAR and any necessary supporting documentation can be attached.
4. Once the provider portion of the form is complete, a pop-up window called "Assign to the Next Participants" appears.
5. Enter the member's name and email address for the member's signature.
6. An email from Adobe is sent to the member with a direct link to sign the form. Once signed, the document is automatically logged in the Enrollment Broker's system and routed to the appropriate entity on the same day.



SERVICE-ASSOCIATED REQUESTS

A Service-associated Request is submitted by the provider, with the member's consent, requesting specific services only available through the LME/MCO or NC Medicaid Direct. If the provider has a member who develops behavioral health, substance use disorder, I/DD or TBI support needs that are not available in the Standard Plans, this allows the member to move to an LME/MCO and/or NC Medicaid Direct to receive services.

A SAR is required (also known as a Treatment Authorization Request) along with any necessary support documentation, to be submitted with Service-associated Requests. Providers should use the Standardized SAR form which is available online with the Request to Move form.

If a service provider plans to serve a beneficairy upon enrollment with LME/MCO they should submit a Service-associated Request. This is an expeditated process. Service-associated Requests are sent to the LME/MCO within 24 hours and the individual is moved within one business day, retroactive to the date of the request.

Submission and Review Process of Service-Associated Requests

Step 1	Step 2	Step 3
The provider submits form to the Enrollment Broker either online at ncmedicaidplans.gov or by fax to 833-898-9655. Additional documentation is included as necessary	Within 24 hours of the provider's submission, the Enrollment Broker will contact the LME/MCO via secure email and send the Service-associated Request and any additional documentation. In addition, the Enrollment Broker will notify the Department's Eligibility Services Team for processing at the same time. If the member meets criteria for NC Health Choice, ages 0-3 or is a fully-qualified immigrant, the form will be reviewed and processed by the Medicaid Vendor instead.	The LME/MCO completes the review of the final SAR. The Enrollment Broker does not provide a review of any SARs. If the LME/MCO or the Medicaid Vendor does not approve the SAR, the member still transitions to NC Medicaid Direct

If approved, Service Associated Requests are effective the date the request was submitted.

NONSERVICE ASSOCIATED REQUESTS

A Nonservice-associated Request does not require a SAR for services and can be submitted directly by a member (using the Request to Move to NC Medicaid Direct or LME/MCO: Beneficiary form). The form can also be submitted by any provider (including the hospital) with the member's consent. Nonservice-associated Requests are reviewed for approval or denial within eight business days for Beneficiary Forms and five business days for Provider Forms.

Submission and Review Process of Nonservice-Associated Requests

Step 1	Step 2	Step 3	Step 4	Step 5
The beneficiary or provider submits the form either online at ncmedicaidplans.gov, by mail or via fax to the Enrollment Broker.	The Enrollment Broker sends the form for review and processing by the Medicaid Vendor, the Department-designated reviewer.	The Medicaid Vendor determines Behavioral Health I/DD Tailored Plan eligibility. If a Nonservice-associated Request is denied, the Department-designated reviewer sends the beneficiary notice with their appeal	The Department-designated Reviewer notifies both the Enrollment Broker and State Eligibility team of the approval. The State Eligibility team updates the beneficiary's Behavioral Health I/DD Tailored Plan Eligibility.	The beneficiary will receive a notice with NC Medicaid Direct enrollment information and an NC Medicaid Direct ID card.

If approved, the request is effective on the first day of the month following the approval.

Beneficiaries with questions regarding the status of the Nonservice-associated Requests, they can contact the Enrollment Broker toll-free at 833-870-5500, option 5.