NC Medicaid Managed Care

Transition of Care Policy

North Carolina Department of
Health and Human Services

Effective: February 24, 2021, updated June 1, 2022

Title: NC Department of Health and Human Services Transition of Care Policy

I. Background

As beneficiaries move between delivery systems, including between health plans, the Department of Health and Human Services (Department or NCDHHS) intends to maintain continuity of care for each Member and minimize the burden on providers during the transition.

- NC Department Health and Human Services published intent for Transitions of Care

A North Carolina Medicaid beneficiary's transition between service delivery systems, including between health plans, poses unique challenges to ensuring service continuity and effective coordination between responsible entities. Transition of Care (TOC) activities applicable to the NC Medicaid Managed Care program are governed by both regulatory and statutory requirements.[1] The Department established its TOC requirements for Standard Plan "Prepaid Health Plans" (PHPs) in its *Request for Proposal 30-190029-DHB Additionally, the Department established its TOC requirements for Tailored Plan PHPs in its Request for Proposal 30-2020-052-DHB.* The term PHP will be used throughout this document to refer to both Standard Plans and Tailored Plans. The NCDHHS Transition of Care Policy aligns and supplements the requirements established in *Request for Proposal 30-190029-DHB*, *Request for Proposal 30-2020-052-DHB* , and subsequent amendments.

II. Scope

While other entities may work under comparable requirements, the scope of this Policy is limited to Transition of Care requirements for NC Medicaid Managed Care PHPs. Accordingly, Medicaid beneficiaries are referred to as "Members".

Further, the Department has released four Disenrollment Protocols to further clarify requirements and processes referenced in this Policy.

Nothing in this Policy shall be construed as an effort to limit, amend or reduce requirements established in the PHP contracts. Any conflict between this policy and a PHP contract shall be determined in favor of the contract.

Although the PHP has the authority to delegate activities under this Policy to Advanced Medical Home (AMH) Tier 3 / Clinically Integrated Network Organizations, the PHP remains responsible for oversight to ensure delegated entities meet transition of care requirements.

[1] See Relevant Legislation section of this Policy

This Policy governs the PHP practices related to TOC and includes the following TOC topics:

- *Ongoing Transition of Care*
  Policy Statement for supporting Members to transition between PHPs or between the PHP and another service delivery system, including disenrollment.
- *Transitional Care Management Requirements*
- *Appendix A: Transition of Care at Crossover NC Medicaid Managed Care Launch*
  *"*Crossover" refers to the Department's conversion to a managed care service delivery system on July 1, 2021.
- *Appendix B: Transition of Care: Special Considerations for Supporting Members Who May Meet Tailored Plan Criteria*
- *Appendix C: Transition of Care Requirements for Service Determinations*
- *Appendix D: Transition of Care: Out-of-Network Provider Flexibilities for Newborn Care*

III. Policy Statement

A. General Transition of Care Requirements

1. The PHP shall develop policies, processes and procedures to support Members transitioning between PHPs or between delivery systems.
2. The PHP shall identify enrolling or disenrolling Members, as defined in the NC Medicaid Managed Care Enrollment Policy, who are transitioning from or to another PHP, NC Medicaid Direct (including behavioral health services provided by Local Management Entity/Managed Care Organization [LME/MCO]), Advance Medical Homes Tier 3 (AMH3), or the Tribal Option.
3. For all Members transitioning from the PHP, the PHP shall transfer the information necessary to ensure continuity of care, including appropriate TOC data files and Member-specific, socio-clinical information.
   a) The PHP shall facilitate the transfer of Member's claims/encounter history and Prior Authorization (PA) data between PHPs and to other authorized Department Business Associates following the data transfer protocols established by the Department and in accordance with related contract and privacy and security requirements.
   b) Transferred Member-specific, socio-clinical information is also referred to as the Member's transition file.[2] A Member's transition file content may vary based on the Member's circumstance but shall, at a minimum, include:

[2] V1.1 Note: Department issued time-limited flexibility to the PHPs to provide the transition summary page and other transition file content *if available* for transitioning Members for transitions through 9/1/2021.

(1) The transitioning Member's most recent care needs screening.

(2) The transitioning Member's most recent care plan (for transitioning care-managed Members and Members disenrolling from the a Managed Care Entity, if available).

(3) A list of any open adverse benefit determination notices for which the appeal timeframe has not yet expired and the status of open appeals.

(4) A TOC Summary Page for each Member identified for a warm handoff and all Members disenrolling from a PHP. This summary page includes minimally:

(a) List current providers.
(b) List of current authorized services.
(c) List of current medications.
(d) Active diagnoses.
(e) Known allergies.
(f) Existing or prescheduled appointments, including Non-Emergency Medical Transportation (NEMT), as known.
(g) Any urgent or special considerations about a Member's living situation, caregiving supports, communication preferences or other Member-specific dynamics that impact the Member's care and may not be readily identified in other transferred documents.

(5) Additional information as needed to ensure continuity of care.

4. Unless otherwise specified in this Policy or applicable protocols, the PHP shall adhere to the following timeframes related to transition data and transition file content transfer:

a) The PHP shall transfer claims, prior authorization and pharmacy lock-in data to the appropriate PHP or receiving entity in accordance with the applicable Transition of Care Data Specification Guidance.[3]

b) The PHP shall initiate a warm handoff, if required or warranted, and transfer the Member's transition file to the applicable PHP or receiving entity on a timeline appropriate to the Member's circumstance but occurring no later than the Member's transition date.

c) If a PHP receives notice of a transitioning Member's enrollment and has not received the applicable transition data file or the Member's transition file within five business days of the transition notice date, the PHP will contact the applicable entity on the following business day to request the transition information as needed.

5. Upon receipt of the relevant Member information, the beneficiary's new PHP shall ensure

[3] medicaid.ncdhhs.gov/transformation/care-management/transition-care-data-specification-guidance

all data as defined by the Department, once received, is transferred to the Member's AMH Tier 3 or Clinically Integrated Network (CIN) coinsurance on the timetables established in applicable AMH Data Specification Guidance.[4]

6. The PHP shall ensure any Member entering the PHP is held harmless by providers for the costs of medically necessary covered services except for applicable cost sharing.
7. The PHP shall allow a Member to complete an existing authorization period established by their previous PHP, LME/MCO or NC Medicaid Direct.
8. The PHP shall assist the Member in transitioning to an in-network provider at the end of the authorization period if necessary.
9. In accordance with N.C. Gen. Stat. §58-67-88(d)-(g), the PHP shall permit the Member to continue seeing their provider, regardless of the provider's network status, in the following instances: A Member transitions into a PHP from NC Medicaid Direct; another PHP or another type of health insurance coverage and the Member is in an Ongoing Course of Treatment or has an Ongoing Special Condition.
10. The PHP shall allow pregnant Members to continue to receive services from their behavioral health treatment provider, without any form of prior authorization, until the birth of the child, the end/loss of pregnancy or loss of eligibility.
11. The PHP shall bear the financial responsibility for non-per-diem diagnosis-related group based inpatient facility claims of an enrolled Member who is admitted to an inpatient facility while covered by the PHP (or prior in the case of a beneficiary who is inpatient on their first day of enrollment in the PHP if there is no prior NC Medicaid Managed Care or FFS coverage for inpatient) through the date of discharge from such facility. Post-discharge care may be coordinated prior to discharge.

B. PHP Transition of Care Policy Content Requirements

1. The PHP shall establish a written PHP TOC Policy which shall include, at a minimum, the requirements in 42 CFR § 438.62(b)(1), 42 CFR. § 438.208(b)(2)(ii) and processes and procedures for:

   a) Coordination of care for Members who have an Ongoing Special Condition.
   b) Coordination of Member transition from NC Medicaid Direct into the PHP.
   c) Coordination of Member transition from LME/MCOs into the PHP.
   d) Coordination of Member transition from the Tribal Option into the PHP.
   e) Coordination of Member transition from the PHP into NC Medicaid Direct, LME/MCO or Tribal Option.
   f) Coordination of Member transition from the PHP to another PHP; coordinate

[4] medicaid.ncdhhs.gov/transformation/advanced-medical-home/advanced-medical-home-data-specification-guidance

Members in the Management of Inborn Errors of Metabolism (IEM) Program, as defined in the PHP's Contract. Coordinate services delivered under other sources of coverage including NC Medicaid Direct.

g) Notify the Department of Members who have had two or more visits to the emergency department for a psychiatric problem or two or more episodes using behavioral health crisis services within the prior 18 months as defined in Section 4.(5) of Session Law 2015-245, as amended by Session Law 2018-48.

h) Educate Members in a manner appropriate to Member's specific circumstance and capacity on the rights provided under this Policy and the processes for maintaining services during transitions of care.

i) Educate a transitioning Member's current provider network on changes to the provider enrollment and reimbursement processes.

j) Other requirements as outlines in this Policy.

C. Additional Transition of Care Requirements for Care-managed Members

1. The PHP's TOC Policy shall integrate processes and procedures for managing the transition of a care-managed Member. Processes and procedures shall reflect the following expectations:

a) Coordinate a timely warm handoff if deemed necessary for effective knowledge transfer or to ensure Member continuity of care.

b) Promote proactive communication with the receiving entity prior to transition to coordinate the transfer of care.

c) Establish a follow-up protocol to communicate with the receiving entity after the Member's transition to confirm receipt of the transferred information and to troubleshoot dynamics that may have resulted from the transition.

d) Recognize population-specific care management requirements as reflected in the PHP's contract (e.g., Long-Term Services and Supports or LTSS) and as outlined in the NCDHHS TOC Policy.

D. Additional Requirements for Members Disenrolling from PHP to NC Medicaid Direct (including LME/MCOs) or Tribal Option

1. The PHPs Transition of Care Policy shall integrate processes and procedures for supporting Members disenrolling to NC Medicaid Direct (including to an LME/MCO) or Tribal Option. The processes and procedures shall reflect the following requirements:

a) Adherence to population-specific Disenrollment Protocols established by the Department, which designate the population's appropriate receiving entity and provide additional population-specific guidance to ensure continuity of care and assist the Member through the disenrollment process.

b) Proactive communication with the receiving entity and the Member, as necessary, to facilitate continuity of care. Communication includes, but is not limited to:

(1) Coordinating a warm handoff with the receiving entity based on timelines established in this Policy.
(2) Post-disenrollment follow-up with the receiving entity to confirm receipt of transition file and consult on transition-related issues.

c) Coordination with entities necessary to ensure Member continuity of care upon disenrollment, including but not limited to:

(1) Coordination with appropriate assessment entities, as applicable, to ensure no disruption in the Member's enrollment in a comparable FFS or program; and
(2) Informing the Member's current Medicaid providers of the anticipated disenrollment.

E. Transition of Care Requirements with Change of Providers

1. The PHP shall develop policies, processes and procedures to support Members transitioning between providers when a provider is terminated from the PHP's network.
2. In accordance with N.C. Gen. Stat. § 58-67-88(d), (e), (f), and (g), instances in which a provider leaves the PHP's network for expiration or non-renewal of the contract and the Member is in an Ongoing Course of Treatment ***or*** has an Ongoing Special Condition, the PHP shall permit the Member to continue seeing their provider, regardless of the provider's network status.
3. In instances in which a provider leaves the PHP's network for reasons related toquality of care or program integrity, the PHP shall notify the Member in accordance with this Section and assist the Member in transitioning to an appropriate in-network provider that can meet the Member's needs.
4. Member Notification of Provider Termination

a. As per 42 CFR § 438.10(f)(1):

(1) The PHP shall provide written notice of termination of a network provider to all Members who received services from the terminated provider within six months immediately preceding the date of notice of termination.

(2) The PHP shall provide the written notice of termination of a network provider to Members within 15 calendar days of the provider termination, except if a terminated provider is an AMH/Primary Care Provider (PCP) for a Member.

b. If a terminated provider is an AMH/PCP for a Member, the PHP shall notify the Member within seven calendar days of the following:

(1) Procedures for selecting an alternative AMH/PCP.
(2) The Member will be assigned to an AMH/PCP if they do notactively select one within 30 calendar days.

c. If a terminated provider is an AMH/PCP for a Member, the PHP shall validate the Member selects or is assigned to a new AMH/PCP within 30 calendar days of the

date of notice to the Member; and notifies the Member of the procedures for continuing to receive care from the terminated provider and the limitations of the extension.

d. The PHP shall use a Member notice consistent with the Department-developed model Member notice for the notification as required by Section 42 CFR §438.10(c)(4)(ii).

1. The PHP shall hold the Member harmless for any costs associated with the transition between providers, including copying medical records or treatment plans.
2. The PHP shall establish a Provider TOC Policy which shall include processes and procedures for:
   a. Coordination of care for Members who have an Ongoing Special Condition.
   b. Coordination for Members discharged from a High-level Clinical Setting.
   c. Coordination for Members seeing a provider that leaves the PHP's network.
   d. Coordination for Members needing to select a new AMH/PCP after a provider termination.
   e. Other requirements as defined in this Section.

F. Transitional Care Management

1. The PHP shall develop policies and procedures for Transitional Care Management consistent with the requirements and protocols provided or referenced in this Policy.
2. The PHP shall manage transitions of care for Members transitioning between PHPs or between payment delivery systems. Care managers assisting Members through the transition or potential transition between PHPs or between payment delivery systems shall follow the requirements and protocols provided or referenced in this Policy.
3. The PHP shall also manage transitions of care (defined as Care Transitions) for all Members moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, emergency department (ED) visits or adverse outcomes.
4. The PHP shall develop a methodology for identifying Members who are at risk of readmissions and other poor outcomes. This methodology shall consider:
   a. Frequency, duration and acuity of inpatient, skilled nursing facility (SNF) and LTSS admissions or ED visits.
   b. Discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center.
   c. Neonatal Intensive Care Unit (NICU) discharges.
   d. Identification of patients by severity of condition, medications, risk score, healthy opportunities and other factors the PHP may prioritize.
5. As part of Transitional Care Management provided to identified Members who are

moving from one clinical setting to another, the PHP shall:

a. Outreach to the Member's AMH/PCP and all other medical providers.
b. Facilitate clinical handoffs.
c. Obtain a copy of the discharge plan and verify the care manager of the Member receives and reviews the discharge plan with the Memberand the facility.
d. Ensure a follow-up outpatient and/or home visit is scheduled within a clinically appropriate time window.
e. Conduct medication management, including reconciliation and support medication adherence though Member education.
f. Ensure a care manager is assigned to manage the transition.
g. Ensure the assigned care manager rapidly follows up with the Member following discharge.
h. Develop a protocol for determining the appropriate timing and format ofsuch outreach.
i. The PHP shall ensure a comprehensive assessment is completed and current for all enrollees upon completion of Transitional Care Management, including re-assessment for enrollees already assigned to care management.

6. The PHP shall have access to an admission, discharge and transfer (ADT) data source that correctly identifies when Members are admitted, discharged or transferred to/from an ED or hospital in real time or near real time.

7. As part of Transitional Care Management, the PHP shall implement a systematic, clinically appropriate process with designated staffing for responding to certain high-risk ADT alerts, including:

a. Real-time (minutes/hours) response to notifications of ED visits, for example by contacting the ED to arrange rapid follow-up.
b. Same-day or next-day outreach for designated high-risk subsets of the population, such as children with special health care needs admitted tothe hospital.
c. Additional outreach within several days after the alert to address outpatient needs or prevent future problems for other patients who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post-discharge).

IV. Definitions and Clarification of Identified Terms

Care Transitions	The process of assisting a Member to transition to a different care setting or through a life stage that results in or requires a modification of services (e.g., school-related transitions).
Crossover Population	NC Medicaid and NC Health Choice beneficiaries who are enrolled in NC Medicaid Direct and will transition to NC Medicaid Managed Care at a specific date established by the Department.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	Medicaid's benefit for children and adolescents under age 21 and in low-income families, includes a broad selection of preventive, diagnostic and treatment services. Also known as the EPSDT benefit, its mandates and guarantees are listed in federal Medicaid law at 42 U.S.C. §1396a(a) (43) and 1396d(r) [1902(a) and 1905(a)(r) of the Social Security Act.
High-level Clinical Settings	• Hospital/inpatient acute care and long-term acute care • Nursing facility • Adult care home • Inpatient behavioral health services • Facility-based crisis services for children and for adults • Alcohol and drug abuse treatment centers (ADATCs)
Local Management Entity/Managed Care Organization (LME/MCO)	LME/MCOs are public managed care organizations that provide a comprehensive behavioral health services plan under the NC 1915(b)(c) Waiver for people in need of mental health, developmental disability or substance use services. LME/MCOs are regionally based.[5]
NC Medicaid Direct	The NC Medicaid Program, excluding NC Medicaid Managed Care. NC Medicaid Direct includes services covered through NC Medicaid; services covered by LME/MCOs and Program for All-inclusive Care for the Elderly (PACE).
Ongoing Course of Treatment	When a Member, in the absence of continued services, reflected in a treatment or service plan or as otherwise clinically indicated, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.
Ongoing Special Condition	As defined in N.C. Gen. Stat. §58-67-88

Disenrollment Protocols	Protocols developed by the Department to be followed by the PHP when assisting designated disenrolling populations through the transition process back to NC Medicaid Direct. Protocols identify the receiving entity for each population and provide interventions to help ensure continuity of care. The Department has established protocols to assist Members who are disenrolling due to Medicare eligibility, Foster Care enrollment, Tailored Plan eligibility and disenrollment into NC Medicaid Direct LTSS program. The Department reserves the right to develop additional protocols as necessary to meet the service continuity needs of disenrolling Members.
Receiving Entity	The entity that is enrolling the transitioning Member and receiving the Member's information.
Transferring Entity	The entity that is disenrolling the transitioning Member and transferring the Member's information.
Transition of Care	The process of assisting a Member to transition between PHPs or between payment delivery systems including transitions that result in the disenrollment from managed care. Transitions of care also include the process of assisting a Member to transition between providers upon a provider's termination from the PHP network. The Department identifies two categories of Transition of Care: **Transition of Care, Crossover:** The timeframe immediately before and after the implementation date of the NC Medicaid Managed Care model in the applicable region. Crossover-related requirements and timeframes are activity specific but are designed to ensure continuity of care for the crossover population during this time of transition. Crossover-specific requirements are provided in Appendix A. **Transition of Care, Ongoing:** The process of assisting a Member to transition between PHPs or to other payment delivery systems, including transitions that result in the disenrollment from managed care. Transitions of care also includes the process of assisting a Member to transition between providers upon a provider's termination from the PHP provider network.

Transitional Care Management	Management of Member needs during Transitions of Care and Care Transitions (e.g., from hospital to home).
Warm Handoff	Time-sensitive, Member-specific planning for Members identified by either the transferring or receiving entity but minimally include: 1) transitioning care-managed Members for whom the PHP deems a warm handoff necessary to ensure continuity of care; 2) Members disenrolling due to Medicare eligibility, foster care eligibility, facility admission that results in disenrollment and Members disenrolling due to LME/MCO service eligibility. Warm handoffs require collaborative transition planning between both transferring and receiving entities and if possible, occur prior to the transition.

[5] The LME/MCO directory can be found here: ncdhhs.gov/providers/lme-mco-directory

Compliance and Monitoring

The Department shall monitor PHP Transition of Care activity through reporting requirements specified in Standard Plan and Tailored Plan contracts on Attachment J of the *Revised and Restated RFP 30-190029-DHB and RFP 30-2020-52-DHB Request for Proposal* and through additional methods as determined by the Department.

Relevant Regulatory and Legislation Citations

42 CFR § 438.10

42 CFR § 438.56

42 CFR § 438.62

42 CFR §438.208

42 CFR §438.214

42 CFR §438.602

N.C. Gen. Stat. § 58-67-88 S.L. 2018-48 (H 403)

Policy Governance and Version Management

Title:	NC Department of Health and Human Services Transition of Care Policy
Contact:	TOC Oversight Team
Enforcing Entity:	NC Department of Health and Human Services – Division of Health Benefits
Approver:	NC Medicaid Executive Review Committee
Date Approved:	v.1 2/17/2021,v.1.1 9/27/2021

Version	Posting Date	Summary of changes
1	2/24/2021	Initial Posting

1.1	9/28/2021	Updated Policy to: • Reflect current Transition of Care requirements and practices. • Memorialize post Standard Plan implementation adjustments. • Incorporate formatting adjustments. • Incorporate *Appendix C, Transition of Care Requirements for Service Determinations*, approved 2/24/2021 for posting. • Incorporate *Appendix D, Transition of Care: Out-of-Network Provider Flexibilities for Newborn Care.*

APPENDIX A

Transition of Care at Crossover

Member transitions between service delivery systems are collectively referred to as Transition of Care. The Department has recognized that Transition of Care involves two distinct phases:

1. Crossover
2. Ongoing Transition of Care

As beneficiaries move between delivery systems, the Department's expectation is processes will be in place that ensure continuity of care for each Member and minimize the burden on providers during the transition. Recognizing the specific dynamics and needs during the Crossover phase, the Department has established time-limited requirements of the PHPs in Appendix A of the TOC Policy.

Crossover: Applicable Definitions

Crossover: The timeframe immediately before and after the implementation date of the NC Medicaid Managed Care model in the applicable region. Crossover-related requirements and timeframes are activity-specific but are all designed to ensure continuity of care for the crossover population during this time of transition.
The timeframe immediately before and after the implementation date of the NC Medicaid Managed Care Tailored Plan model in the applicable region. Crossover-related requirements and timeframes are activity-specific but are all designed to ensure continuity of care for the crossover population during this time of transition.

Crossover Timeframe: The timeframe immediately before and after the implementation date of NC Medicaid Managed Care. Crossover-related requirements and timeframes are activity-specific but are all designed to ensure continuity of care for the Crossover Population during this time of transition.

Episode of Care: A treatment or intervention covered under the Standard Plan benefit, initiated prior to NC Medicaid Managed Care Launch and evidenced by a current treatment plan, which is related to a Member's condition or circumstance and is provided to the Member by the non-participating provider within the first 60 days after NC Medicaid Managed Care Launch.

A treatment or intervention covered under the Tailored Plan benefit, initiated prior to NC Medicaid Managed Care Tailored Plan Launch and evidenced by a current treatment plan, which is related to a Member's condition or circumstance and is provided to the Member by the non-participating provider within the first 60 days after Tailored Plan Launch.

High-need Member: individuals requiring time-sensitive, Member-specific follow up by the PHPs during Crossover. High-need Members include, but are not limited to, Members who are receiving or authorized to receive the following services:

- High-need subset of Members receiving LTSS.

- Members receiving or authorized to receive private duty nursing services who have also experienced one or more ED visits or hospitalizations within 30 calendar days of NC Medicaid Managed Care Launch and/or Tailored Plan Launch.
- Members receiving or authorized to receive Home Health services who have also experienced one or more ED visits or hospitalizations within 30 calendar days of NC Medicaid Managed Care Launch and/or Tailored Plan Launch.
- Members who have received home infusion therapy services, with dates of service within 30 days of NC Medicaid Managed Care Launch and/or Tailored Plan Launch.
- Members who have been enrolled in a Nursing Facility for 30 calendar days or less at NC Medicaid Managed Care Launch and/or Tailored Plan Launch.[6]
- Members authorized for 80 or more hours a month of Personal Care Services (PCS) or minors receiving PCS.

- Members receiving crisis behavioral health services within six months of NC Medicaid Managed Care Launch and/or Tailored Plan launch.
- Members with Inborn Errors of Metabolism.
- Members identified by CCNC, AMH3's, an LME/MCO or the Department who have complex treatment circumstances or multiple service interventions and necessitate a warm handoff.
- Members who are experiencing a care transition from a high-level clinical setting.
- Identified Standard Plan-exempt Members who elected to enroll in a Standard Plan.
- Members authorized for a transplant procedure.
- Members authorized for out-of-state services.
- Other high-need Members or group of Members identified by the Department or the PHP.

NC Medicaid Managed Care Launch The date on which the NC Medicaid program converts from a fee-for-service delivery model to a managed care delivery model for enrolled beneficiaries. This date is also referred to as Implementation.

Tailored Plan Launch The date on which the NC Medicaid program implements comprehensive behavioral health services Managed Care model for enrolled beneficiaries.

Warm Handoff Member-specific meeting/knowledge transfer session between transferring entity and receiving entity. Members requiring a warm handoff at Crossover may be identified by either the Member's PHP or applicable NC Medicaid Direct "transferring entity", but the Department anticipates the transferring NC Medicaid Direct program will be better positioned to determine if a Member's specific circumstance requires a formal warm handoff briefing.

Follow-up Direct contact with the identified Member/authorized representative to confirm continuity of services; to provide any Member-specific PHP contact information directly to Member/authorized representative and to address any Crossover-related issues the Member may be experiencing. PHPs shall prioritize follow-up activity with high-need Members based on urgency of need but should strive to conduct follow-up with identified high-need Members no later than three weeks following NC Medicaid Managed Care Launch and/or Tailored Plan

launch.

Key Services Key services are defined by the Member, the PHP and/or care plan, but shall minimally include NEMT maintained without disruption, LTSS in-home service supports have continued without disruption, medications have been refilled as scheduled and behavioral supports have continued without disruption.

[6] V1.1 Note: In anticipation of higher than projected volume, Department modified High Need Member population scope on June 8, 2021: a) prioritized follow up to PCS Members authorized for 91 or more hours; removed nursing facility residents from scope for follow up; Tailored Plan-Eligible Members who elected to enrollin Standard Plan were later removed due to change in Department's direction to delay Tailored Plan-Eligible Members' enrollment in Standard Plan PHP on 7/1/2021.

Crossover Requirements: Data Transfer and PHP Acceptance of Data Files

Requirements

- PHPs have the capacity to accept, ingest and use claims, encounter, pharmacy lock-in files and prior authorization data files identified in the *Transition of Care: Technical Implementation Overview and Schedule* and subsequent guidance.
- PHPs have the capacity to accept, ingest and use service assessment and care plan detail available to the PHP.
- PHPs participate in the Department's strategy to minimize service disruption at Crossover due to erroneously submitted Prior Authorizations. Participation includes but is not limited to:
    - Providing information about the PHP's prior authorization process to be included in the Department sponsored PHP PA Resource webpage.
    - Establishing the functionality necessary to accept warm transfer calls from Utilization Management Vendors and receive a call-in PA request.
    - Provide related data as identified in the *Crossover Requirements: Reporting* section of the Appendix.
    - Participate in provider education efforts as provided in the *Crossover Requirements: Provider Education* section of the Appendix.

Crossover Requirements: Management of High Need Member Supports and Services

Requirements

- PHPs participate in Member-specific knowledge transfer sessions known as warm handoffs for Members identified by either transferring entity or by the PHP. Warm handoffs will begin three weeks prior to NC Medicaid Managed Care Launch and/or Tailored Plan Launch, and be completed no later than one week after launch.

- PHPs provide expedited follow up after NC Medicaid Managed Care Launch and/or Tailored Plan Launch with high-need Members as defined within this Appendix to:
    - Ensure identified services have continued without disruption.
    - Initiate post-NC Medicaid Managed Care Launch assessments that may be required to evaluate the Member's continuation of services after 90 days.
    - Ensure uninterrupted access to NEMT.
- PHPs provide high-need Member level updates to the Department in a manner identified by the Department and as outlined in the Reporting section of the TOC Policy.

Crossover Requirements: NEMT Management

Requirements

- PHPs begin accepting requests for NEMT scheduling for post-NC Medicaid Managed Care Launch and/or Tailored Plan Launch appointments from enrolled Members no later than one month prior to NC Medicaid Managed Care Launch and/or Tailored Plan Launch.

Crossover Requirements: Honoring Existing and Active FFS PAs for 90 Days Post-NC Medicaid Managed Care Launch and/or Tailored Plan Launch

Requirements

- To ensure continuity of care for Members, the PHP must honor existing and active medical PAs on file with NC Medicaid or NC Health Choice for, at a minimum, the first 90 days after implementation or until the expiration/completion of a PA, whichever occurs first. For service authorizations managed by an LME/MCO and under the scope of 42 CFR Part 2, the PHP shall deem authorizations submitted directly by impacted providers as covered under this requirement.
- FFS Utilization Management Vendors and Behavioral Health LME/MCOs will continue to receive PA requests up to 11:59 p.m. pre-NC Medicaid Managed Care Launch and/or Tailored Plan Launch, and process those requests per their standard processes and service-level agreements (SLAs), even if processing continues beyond NC Medicaid Managed Care Launch and/or Tailored Plan Launch. Accordingly, the PHP may receive additional FFS PAs on the incremental PA transfer file after NC Medicaid Managed Care Launch and/or Tailored Plan Launch. The PHP shall honor these FFS PAs for the first 90 days after NC Medicaid Managed Care Launch and/or Tailored Plan Launch, following the related requirements and protocols established for FFS PAs.
- At the launch of Tailored Plan, the LME/MCOs delivery of services for individuals enrolled in the Tailored Plan will end and provision of these services will transfer under the scope of

the Medicaid Managed Care Tailored Plan contract.

- For new PA requests submitted by providers to the PHP on or after NC Medicaid Managed Care Launch and/or Tailored Plan launch, standard utilization management requirements and allowances as specified in the PHP contracts apply. New PA requests submitted by providers to the PHP may include requests for reauthorization of services initially authorized in FFS.
- PHPs are strongly advised to consider the Member's prior service history and prior clinical circumstance when reviewing new PA requests, including reauthorization requests, during the Crossover time.

Crossover Requirements: PHP Payment of Services in Place at Crossover

Requirements

- Generally, PHPs assume responsibility for services with dates of service on or after the applicable NC Medicaid Managed Care Launch and/or Tailor Plan Launch date.
- For the first 60 days after NC Medicaid Managed Care Launch and/or Tailored Plan Launch, PHPs are required to pay claims and authorize services for Medicaid-eligible, out-of-network providers equal to that of in-network providers until the end of Episode of Care or 60 days, whichever is less.[7] Unless the Member has an Ongoing Special Condition or is under an Ongoing Course of Treatment. In these circumstances, the PHP shall follow the timeframes provided in N.C.Gen. Stat. § 58-67-88(d), (e), (f), and (g).[8]
- For Medicaid beneficiaries who are admitted to an acute care facility and eligible for full Medicaid fee-for-service coverage prior to NC Medicaid Managed Care Launch and/or Tailored Plan Launch, and discharged after NC Medicaid Managed Care Launch and/or Tailored Plan Launch, NC Medicaid Direct will pay DRG-associated claims.

Crossover Requirements: Additional Prior Authorization Dynamics

Requirements

- Unmanaged Visits for Outpatient Behavioral Health Services
  Per the PHPs contract, PHPs are required to adhere to the Department's Clinical Coverage Policy 8C, *Outpatient Behavioral Health Services Provided by Direct-enrolled Providers.*
  This policy states in relevant part: *Outpatient behavioral health services coverage is limited to eight unmanaged outpatient visits for adults and 16 unmanaged outpatient visits for children per state fiscal year (inclusive of assessment and Psychological Testing codes)*. **For Members authorized for services under this Clinical Coverage Policy at NC Medicaid Managed Care Launch and/or Tailored Plan Launch, the unmanaged visit count shall reset to zero**. PHPs are otherwise required to adhere to Clinical Coverage Policy 8C, *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers.*

Crossover Requirements: PHP Governance Processes

Requirements

- The PHP's TOC Policy shall reflect how the PHP will monitor the implementation and ongoing activity related to the requirements identified in the Appendix.
- The PHP shall participate in state-sponsored Crossover-specific monitoring activities including but not limited to:
    - Time-limited Crossover "stand up" meetings with NC Medicaid staff and vendors on a schedule to be determined by the Department.
    - Time-limited, rapid cycle solutioning process related to data transfer issues and Member disruption in care.
    - Complete and submit Crossover status reports and data reconciliation detail as outlined in the *Crossover Requirements: Reporting* section of the Appendix.

[7] See Standard Plan contract at Revised and Restated RFP 30-190029-DHB Request for Proposal Section V. Scope of Services Page 88 of 214

[8] V1.1 Note: The Department amended this requirement through subsequent communications, see July 7, 2021 communication Prepaid Health Plan Flexibility for Prior Authorizations During First 60 days after Managed Care Launch; see August 27, 2021, communication In-network Provisions Extended Through September

Crossover Requirements: Reporting

Requirements

- The PHP shall participate in file transfer, data reconciliation processes and reporting as identified by the Department.
- The PHP shall provide status reports on engagement activities and service disposition of high-need Members.
- The PHP will track and has the capacity to report and reconcile Member-specific data related to:
    - NEMT appointments received during Crossover period.
    - Open appeals at NC Medicaid Managed Care Launch.
    - Open appeals at NC Medicaid Managed Care Tailored Plan Launch.
    - Post-NC Medicaid Managed Care Launch PA unit use.
    - Post-NC Medicaid Managed Care Tailored Plan Launch PA unit use.

Crossover Requirements: Member and Provider Education

The Department will not require formal call center scripts for Crossover-specific dynamics. The Department will establish Crossover-specific “talking points” the PHP will incorporate into its Call Center protocols and staff training, providing additional training to the PHPs as needed. The Department will finalize these talking points and require the PHP to attest to the training and integration of these statements into its Call Center protocols at a later date, as determined by the Department.

Crossover-related Call Center content will include:

- Guidance to providers about identifying Member’s plan enrollment status.
- Guidance to providers on Crossover-related PA submission requirements.
- Guidance to providers on applicable continuity of care provisions in the Standard Plan contract and subsequent policy statements.
- Guidance to Members on pre-NC Medicaid Managed Care Launch scheduling of post-NC Medicaid Managed Care Launch NEMT appointments.
- Guidance to Members on pre-NC Medicaid Managed Care Tailored Plan Launch scheduling of post-NC Medicaid Managed Care Tailored Plan Launch NEMT appointments.
- Additional guidance as necessary to ensure Member continuity of care and provider clarity on applicable Crossover processes.

Crossover Requirements: Crossover-Specific Considerations for Adverse Determination

- Generally, PHP activity is governed by *Member Grievances and Appeals* section of Revised and Restated RFP.[9]

[9] Revised and Restated RFP 30-190029-DHB Request for Proposal Section V. Scope of Services Page 35 of 214

- The PHP and the Department shall follow any resulting order by Office ofAdministrative Hearings (OAH) or another court.

Appeals-related Considerations at Crossover
Requirement: Pre-NC Medicaid Managed Care Launch and/or Tailored Plan Launch PA Processing Utilization Management Vendors *(or state staff, as applicable)* will continue to receive PA requests up to 11:59 pre-NC Medicaid Managed Care Launch (or Implementation) and process those requests per their standard processes and SLAs. • If the PA review process extends beyond NC Medicaid Managed Care Launch and is authorized, the PHP shall honor for the duration of the authorization or 90 days after NC Medicaid Managed Care Launch, whichever occurs first.
• If the PA review process extends beyond NC Medicaid Managed Care Launch, is not authorized and this adverse determination results in an appeal, the Department will seek to dismiss the appeal on the grounds identified in this Appendix.
Requirement: Maintenance of Service (MOS) If FFS Maintenance of Service (MOS) is in effect for a Member at NC Medicaid Managed Care Launch, for a service covered by the PHP, the PHP is financially responsible for post-NC Medicaid Managed Care Launch services provided under MOS until the PHP reassesses and either approves the service or issues its own adverse decision with appeal rights.
Position Statement: The Disposition of MOS/COB (Continuation of Benefits) for LME/MCO-Sponsored Services for Member who Transfers to the PHP (NEW) • If MOS/COB is for service *not* covered by PHP and Member has voluntarily, proactively transferred from LME/MCO to PHP (Standard Plan Exempt), Member has waived MOS upon transfer. • If MOS/COB is for service that is covered by PHP, MOS protocol outlined in MOS Requirement applies.
Position Statement: Retroactive PA Requests If a provider submits a *retroactive* PA covering both a fee-for-service and PHP timespan, the UM entity receiving the retroactive PA request may review only the portion of the request covering the timespan under its authority.

Requirement: Related to *Position Statement, Retroactive PA Requests*

- The receiving entity must inform the provider of its inability to process the portion of the request that is out of the receiving entity's authority
- The provider will need to submit the remaining units to the appropriate authorizing entity.
- If the receiving entity reviews and denies the portion of the request within its authority, it must also issue appeal rights.

Requirement: PHP honoring FFS PAs after NC Medicaid Managed Care Launch and/or Tailored Plan Launch

The PHP must honor open FFS PAs for first 90 days after NC Medicaid Managed Care Launch or to the date the PA expires or is concluded, if sooner than 90th day after NC Medicaid Managed Care Launch / Implementation date.

Requirement: Appeal Rights on Terminated or Reduced pre-NC Medicaid Managed Care Launch and/or Tailored Plan Launch Authorized Services.

If a PHP terminates/reduces an FFS-authorized service after the 90 days, PHP must issue appeal rights. A PHP reassessment that potentially results in termination or reduction in services should begin sufficiently in advance of the 90th day, to remain in compliance with requirements specified in Member Grievances and Appeals section of Revised and Restated RFP.

- Related Reporting Requirement: PHP adverse determination on an FFS authorized service should be uploaded into the Medicaid Appeals and Grievance Clearinghouse.

APPENDIX B

Transition of Care: Special Considerations for Supporting Members Who May Meet Tailored Plan Criteria

Overview

This Appendix establishes the Department's requirements of Standard Plan PHPs to assist transitioning Members who are eligible for Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Plans or, prior to Behavioral Health I/DD Tailored Plan launch, for LME/MCO enrollment.

Specifically, this Appendix includes requirements related to supporting:

1. Standard Plan Members who are not required to enroll in the Standard Plan because of Tailored Plan eligibility, but elect to do so; and
2. Standard Plan Members who may become Tailored Plan-eligible following their enrollment in Standard Plans.

The statements included in this Appendix are aligned with the Department's intended design outlined in:

1. NC Medicaid Managed Care Final Policy Guidance Behavioral Health and Intellectual/Developmental Disability Tailored Plan Eligibility and Enrollment (Final Policy Guidance) and related updates.
2. The Department's report to the NC General Assembly's Joint Legislative Oversight Committee, Plan for Implementation of Behavioral Health and Intellectual/Developmental Disabilities Tailored Plans, (Plan for Implementation).
3. In accordance with related legislation.

Definitions

Behavioral Health I/DDTailored Plan:

Tailored Plans are specialized managed care products targeting the needs of individuals with significant behavioral health disorders, intellectual and developmental disabilities and traumatic brain injuries (TBI). These plans are scheduled to begin in December 1, 2022. Prior to launch, beneficiaries meeting eligibility for the Tailored Plans will continue to be covered through the current NC Medicaid Direct / LME/MCO system.[10]

[10] nc.gov/ncdhhs/medicaid/BH-IDD-TP-Eligibility-Enrollment-Update-FINAL-20190716.pdf

Behavioral Health I/DD Tailored Plan Eligible/ Meeting Tailored Plan Criteria: Beneficiaries who are eligible and auto-enrolled in a Tailored Plan (or NC Medicaid Direct / LME/MCOs prior to Tailored Plan launch) and meet the criteria provided in *NC Medicaid Managed Care Behavioral Health and Intellectual/Developmental Disability Tailored Plan Eligibility and Enrollment APPENDIX B, Behavioral Health I/DD TAILORED PLAN CRITERIA, updated August 2, 2019, and February 2, 2021*.[11]

Beneficiaries who are not initially identified as Tailored Plan eligible will be able to request a review to determine whether they are eligible to enroll in a Tailored Plan.[12]

Tailored Plan Eligibility Request Process: The process established to support Standard Plan enrolled Members wishing to request transfer into the Tailored Plan or preceding the launch of Tailored Plan, for NC Medicaid Direct due to the need for services provided by the LME/MCO.[13]

Overarching Expectation of Support for PHP Members Who May Meet Tailored Plan Criteria

A Standard Plan shall effectively provide behavioral health supports to its Members, which include ensuring that its Members have access to clinically indicated behavioral health services within the Standard Plan's scope. If a Member requires services or interventions available only through the Tailored Plan or LME/MCO prior to Tailored Plan Launch, the Standard Plan shall support the Member to understand the service options available and assist the Member through any subsequent transition to the Tailored Plan or LME/MCO.

Special Transition of Care Considerations for Members Who May Meet Tailored Plan Criteria

DHHS Policy Positions and Requirements

- Medicaid beneficiaries identified as eligible for the Tailored Plans default to LME/MCO enrollment until Behavioral Health I/DD Tailored Plans launch but will have the option to enroll in a Standard Plan PHP.[14] Members who are eligible for the Tailored Plan but have chosen to enroll in a Standard Plan will be identifiable on the 834 Eligibility File. Tailored Plan eligible Members who remain in or return to the Standard Plan shall be designated by the PHP as a Priority Population for Care Management under the Adults and Children with Special Healthcare Needs category.

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11 nc.gov/ncdhhs/medicaid/BH-IDD-TP-EligibilityUpdate-AppendixB-REVFINAL-20190802.pdf
nc.gov/ncdhhs/BH-IDD-TP-Eligibility-Enrollment-Update-02.02.2021.pdf

12 nc.gov/ncdhhs/medicaid/BH-IDD-TP-EligibilityUpdate-AppendixB-REVFINAL-20190802.pdf
This list includes both those Members whose enrollment may default to LME/MCO or Tailored Plan but may electto enroll in the Standard Plan and those Members who may be later identified as Tailored Plan-Eligible. For additional clarification, please review the *Final Policy Guidance*.

13 Additional description can be found at:
nc.gov/ncdhhs/medicaid/BH-IDD-TP-Eligibility-Enrollment-Update-FINAL-20190716.pdf

14 NC Medicaid Managed Care Final Policy Guidance Behavioral Health I/DD Tailored Plan Eligibility and Enrollment
pg. 6. Medicaid beneficiaries enrolled in the Innovations and TraumaticBrain Injury waivers will be required to disenroll from their waivers prior to enrolling in Standard Plan

- To ensure access to necessary services, the Department established the following pathways for identifying Standard Plan Members who may be more appropriately served under the Tailored Plan (or by LME/MCO prior to Tailored Plan launch):
    - Members identified through the Department Claim and Encounter Review.
    - Members identified through the Behavioral Health I/DD Tailored Plan Eligibility Request process.
    - Members who experience other qualifying events, as reflected in the Tailored Plan eligible definition within the Appendix.
- The Standard Plan shall follow protocols set by the Department related to identifying, reporting and assisting applicable Standard Plan Members who may be more appropriately served under the Tailored Plans (or only by NC Medicaid Direct / LME/MCOs prior to the Tailored Plan launch).
- To assist Members who may be eligible for Tailored Plans, the Standard Plan shall train care managers in services available only through Tailored Plans, Behavioral Health I/DD Tailored Plan eligibility criteria and the process for an enrollee who needs a service that is available only through Tailored Plans to transfer to a Tailored Plan.
- The Standard Plan shall establish internal policies and procedures for assisting Members who may be eligible for Tailored Plans and supporting those who elect to transfer during the transition to Tailored Plans or LME/MCOs prior to the Tailored Plan launch. At a minimum, these policies and procedures shall be aligned with Standard Plan's overarching TOC policy, its procedures specific to disenrollment and transitioning care managed populations and shall also establish:
    - Internal operational processes for coordinating with providers on the submission of a Transition Request form as defined in the in Appendixes in this Policy.
    - Internal operational processes for coordinating with Department on supporting the transition of Members identified for disenrollment due to Tailored Plan eligibility.
    - Follow-up protocols for newly enrolled Members consistent with those provided in *Additional Transition of Care Requirements for Care Managed Members* section of the TOC Policy.
- Standard Plans are required to provide North Carolina Medicaid State Plan Behavioral Health or I/DD services subject to EPSDT that are typically offered only by Tailored Plans to children under age 21 who require a service. EPSDT does not cover habilitative services, respite services or other services approved by CMS that can help prevent institutionalization. Those services will only be available in the Tailored Plans.
- If a Medicaid-enrolled child is enrolled in a Standard Plan PHP and needs a service that is covered in the Tailored Plans service array (but not Standard Plans) and the service meets the requirements for EPSDT, the Standard Plan PHP must cover that service for any period the beneficiary is enrolled with that PHP. When the encounter for that service

comes to the Department, the Department will flag the beneficiary as Tailored Plan eligible and they will be disenrolled from the PHP and moved into NC Medicaid Direct (until Tailored Plans go live), in accordance with the auto-enrollment of Tailored Plan eligible Members.

- The Standard Plan shall report on activities related to identifying, reporting and assisting Tailored Plan eligible Members, in a manner specified by the Department.
- For all Members referenced in the Appendix who transition to an LME/MCO or a Tailored Plan, Transition of Care requirements, as specified in the Standard Plan Contract at *Revised and Restated RFP 30-190029-DHB Request for Proposal, Section V.C.4* and the TOC Policy apply. All applicable requirements will be reflected in the Department's TOC Policy.

Appendix C

Transition of Care Requirements for Service Determinations

To ensure continuity of care for adverse determinations impacted by a Member's transition, the PHP shall adhere to the following requirements.

A. General Requirements

1. Generally, PHP appeals, and State Fair Hearings (SFH) activity are governed by *Member Grievances and Appeals* section of Revised and Restated RFP.[15]
2. The PHP and the Department shall follow any resulting order by OAH or another court.
3. As specified in this Policy, the PHP will communicate the status of any open, adverse benefit determinations and related appeals and SFH as part of its transition file content.
4. The PHP and the Department must adhere to all applicable state and federal requirements.
5. EPSDT may alter the positions established in this Appendix.

B. Requirements When a Member Transitions Between PHPs

1. PA Requests Submitted Prior to the Member's Transition.

   If a PA request is submitted prior to the Member's transition date, the Member's current PHP will review following established SLA timeframes and established in TOC requirements.

   a) For Initial Requests[16] with a requested start date prior to the transition, the PHP will review and either approve or make an adverse determination with appeal rights.

      (1) If the Member's appeal with the originating PHP is live at transition, the appeal process continues, though the originating PHP may be unable to render a determination due to the dates of service requested. If unable to render a determination, the originating PHP will communicate its position through a Notice of Decision/Resolution with SFH appeal rights. The originating PHP will include in its communication instruction to resubmit the request to the member's new PHP.

      (2) If the SFH is live at transition, the appeals process continues, though the originating PHP may not have the authority over the Member's services. The originating PHP will communicate its position through the SFH process

[15] Revised and Restated RFP 30-190029-DHB Request for Proposal Section V. Scope of Services Page 35 of 214

[16] Initial Requests: requests that have not previously been approved (whether the services themselves are ongoing or finite)

and will also direct the Member to resubmit the request to Member's new PHP.

b) For Initial Requests with a requested start date occurring after the Member's disenrollment from the PHP to another PHP or to NC Medicaid Direct (i.e., the entire required authorization period occurs after the Member's transition to new PHP or to NC Medicaid Direct) that is submitted after the known transition date (Notice Date), the current PHP is not required to process but must issue its unable to process notice to the Member and communicate this position to the provider.
c) For Initial Requests submitted with start date after the Member's Medicaid eligibility ends, the PHP shall review and process the request based on medical necessity, in the event the Member's Medicaid eligibility is extended. Payment by the PHP for services rendered may be contingent on the Member's managed care enrollment status on the date of service.
d) For a request for reauthorization of service[17] with requested reauthorization date prior to the transition, the PHP will review the full date span and either approve or make an adverse determination with appeals rights.

    (1) If, at or after the transition, a Member has timely requested COB the Member's new PHP must continue benefits at the originally authorized level until it reassesses the Member and renders its own determination or until the end of benefit authorization period, whichever occurs first.
    (2) If, at transition, a Member is within the timeframe to request COB, the Member's new PHP must continue benefits at the originally authorized level until the end of the COB request timeframe.
    (3) If, at transition, a Member is within the timeframe to request COB, the Member's new PHP must continue benefits at the originally authorized level until the end of the COB request timeframe.
    (4) If, after transition, the Member's new PHP, upon reassessing the Member, also chooses to reduce or terminate the benefit, the new PHP must issue a Notice of Adverse Benefit Determination with appeal rights and a new COB timeframe. If the Member appeals and timely requests COB under the new timeframe the Member will retain the original level of authorized service until the appeal is resolved.
    (5) If the Member's appeal with the originating PHP is live at transition, the appeal process continues, though the originating PHP may be unable to render a determination due to the dates of service requested. If unable to render a determination, the originating PHP will communicate its position

[17] Request for reauthorization of service: requests where there is a prior, open approval for a service and adverse determination will potentially result in ongoing service implication

through a Notice of Decision/Resolution with SFH appeal rights. The originating PHP will include in its communication: The Member's benefits have transferred to the new PHP and restate the State's expectations that COB, timely requested, will be maintained by the Member's new PHP until the new PHP reassesses and makes a determination.

(6) If the SFH is live at transition, the appeals process continues, though the originating PHP may not have authority over the Member's ongoing services. The originating PHP will communicate its position through the SFH process. Through the SFH process, the originating PHP will also inform the Member that benefits have transferred to the new PHP and restate the State's expectations that COB, timely requested, will be maintained by the Member's new PHP until the new PHP reassesses and decides.

e) For a request for reauthorization of service with the requested reauthorization date occurring after the Member's disenrollment from the PHP (i.e., the entire requested reauthorization period occurs after the Member's transition) that is submitted after the Member's known transition date (Notice Date) the PHP is not required to process but must issue an unable to process notice to the Member and communicate this position to the provider.

(1) In accordance with the Department's Transition of Care data transfer requirements, the current authorization will transfer to the Member's new PHP. Upon transition, the Member's new PHP will make its independent determination.

2. Prior Authorizations Erroneously Submitted to a Member's Previous PHP for Service Dates on or after the Member's Transition

a) If a PA request is submitted to a Member's previous PHP after the Member's transition date, the Member's previous PHP will reject the PA unreviewed and redirect the submitter to the Member's current PHP.

(1) This rejection does not trigger appeal rights.

3. Retroactive Prior Authorization Submitted to the Member's Previous PHP for Dates of Service the Member was enrolled with Previous PHP

a) Excluding DRG-based services, the Member's previous PHP shall review the retroactive PA request for dates when the member was enrolled.
b) If not approved, the Member's PHP must issue a notice of adverse benefit determination with appeal rights for dates of service within its coverage span.

4. Appeals of Involuntary Disenrollment from PHP

a) A Member who has experienced a PHP-initiated involuntary disenrollment may appeal the determination following processes established in the PHP contract.
b) The PHP will follow applicable transition of care requirements for Members

transitioning due to involuntary disenrollment and due to the outcome of related appeals.

C. Requirements When a Member is Disenrolling to NC Medicaid Direct (including LME/MCO)

1. For Members disenrolling to NC Medicaid Direct, including to an LME/MCO, the PHP shall follow requirements for processing Initial Requests established under *Requirements when a Member Transitions Between PHPs* section of the Appendix.
    a) If the PHP adverse determination is made with COB rights, the PHP COB timeframe of 10 days applies, even if the Member is transitioning to NC Medicaid Direct.
2. For service authorization requests erroneously submitted to the PHP after the Member's transition, the PHP shall follow requirements for erroneous submissions established under *Requirements when a Member Transitions Between PHPs* section of this Appendix.

D. When Disenrollment to NC Medicaid Direct Results in a Reduction in Services Authorized by the PHP

1. As a general policy, hours or units remaining for a service authorized by a PHP and covered by NC Medicaid Direct will transfer with the transitioning Member up to the NC Medicaid Direct benefit limit.
2. If a Member transitions with unused hours or units that exceed the NC Medicaid Direct benefit limit, the available hours or units will be adjusted upon transition to align with applicable Medicaid benefit limits.

Appendix D

Transition of Care: Out-of-Network Provider Flexibilities for Newborn Care

As confirmed on March 15, 2021,and communicated in Managed Care Eligibility for Newborns: What Providers Need to Know:

- A health plan is assigned to a newborn retroactive to the first day of the month of birth. The provider is required to file claims to the newborn's card once the card is issued. The health plan assigned is responsible for covering all costs incurred since birth. If the newborn is assigned to the mother's (or sibling's) health plan, that family member has 90 days from the effective date of enrollment in the health plan to change their plan.

- If the newborn changed plans, the new health plan would be responsible starting the first of the following month (when the new enrollment is effective).

- Health plans will treat all out-of-network providers the same as in-network providers for purposes of PA and will pay out-of-network providers the NC Medicaid Direct rate for services rendered through the earlier of:

    1. 90 days from the newborn's birth date or
    2. The date the health plan is engaged* and has transitioned the child to an in-network PCP or other provider.

* In the above, "engaged" means the PHP has assigned the newborn to an in-network PCP and the newborn has visited that in-network PCP. Once the newborn visits their in-network PCP, this provision would end, even if the visit occurs prior to 90 days from the newborn's birth date. This provision covers all medically necessary care provided by any health care provider, not just primary care providers, which includes hospitals and/or facilities. When a child is enrolled in a health plan, that health plan will be visible to providers when they confirm the child's eligibility. Providers should bill the health plan the child is enrolled in, regardless of whether they are in-network or out-of-network. Providers should know they may initially get a denial, but most health plans have an extenuating circumstances review that will allow payment. Providers should work with health plans to ensure payment.