Fact Sheet: Panel Management for Primary Care Practices

WHAT IS THE PANEL MANAGEMENT: ENROLLEE REPORT?

To assist with identifying North Carolina Medicaid and NC Health Choice members currently assigned to practices under the Community Care of North Carolina/Carolina ACCESS (CCNC/CA) and Advanced Medical Home (AMH) programs, DHHS generated a new Enrollee Report for distribution to CCNC/CA/AMH participating providers. The Enrollee Report allows CCNC/CA/AMH Providers to know their assigned member list each week. The Enrollee Report is called the AMH Medicaid Direct/Managed Care PCP Enrollee Report and contains information on members assigned in Medicaid Direct and Managed Care.

The Enrollee Report is delivered each month to the NCTracks Secure Provider Portal Message Inbox the Monday before the second checkwrite to coincide with the receipt of CCNC/CA management fees. This began on March 15, 2021.

WHAT INFORMATION IS SHOWN IN THE PANEL MEMBER REPORT?

The AMH Medicaid Direct/Managed Care PCP Enrollee Report ("Enrollee Report") contains a list of all NC Medicaid beneficiaries who have been assigned to the identified National Provider Identifier (NPI) in the past 12 months and contains:

- NPI/Atypical ID
- Provider name
- Service location address (to which the member is assigned)
- Medicaid Identification Number
- Recipient name
- Date of birth
- Active (Y or N) (currently enrolled in Medicaid and assigned to you)
- Assignment program (i.e. Med-Dir for NC Medicaid Direct)
- Effective date (of assignment)
- End date (of assignment)
- Last office visit (based on paid claims from the billing NPI)
- Total visits (based on paid claims for the past 12 months)

To effectively use the report, add filters or sort the report based on an Active status of "Y." In this way, the provider can narrow the results to display only those currently enrolled in NC Medicaid and assigned to the identified NPI. PCP changes are always effective the first day of the following month and will be reflected on the new monthly report.

A PCP practice reassignment process occurred March 20 and 21, 2021 to be effective April 1, 2021. This impacted only beneficiaries who had not visited their current PCP in the last two years and have an active treatment relationship with a different PCP. The April Enrollee Report, available April 12, 2021, reflected any changes made during the reassignment. Please see the Primary Care Provider Practice Reassignment for Some Beneficiaries bulletin article at https://medicaid.ncdhhs.gov/blog/2021/04/01/primary-care-provider-practice-reassignment-some-beneficiaries, for more information on that change.

Although the AMH Medicaid Direct/Managed Care PCP Enrollee Report does not currently identify the benefit program (Medicaid or NC Health Choice) of the beneficiary, the report includes functionality to identify health plan members and the name of the health plan to which each is assigned beginning in future iterations. The June 2021 report contains only Medicaid Direct members and subsequent monthly reports will contain Medicaid Direct and Health Plan assignment information. DHHS is working to prepare a supplement to the June enrollee report that list Managed Care assignment data.

For more information, see AMH NC Medicaid Direct/Managed Care PCP Enrollee Report – How to Read & Use Your Enrollee Report, available here.

HOW DO I SELECT OR MODIFY MY PANEL SIZE BEFORE LAUNCH?

NC Medicaid providers participating as a CCNC/CA provider may select or modify their panel size during their initial enrollment application, or through the Manage Change Request (MCR) process. This panel size limitation applies to NC Medicaid Direct enrollees. For NC Medicaid Managed Care, providers are encouraged to establish their panel size during the contracting process with the health plan. Health plans are contractually required to allow AMH/PCPs to set limits on panel size and have a process by which to do so. Once contracted, the health plan must offer information regarding the process to modify the information.

For assistance with modifying the panel size (referred to as the enrollment limit) on your NCTracks record for NC Medicaid Direct beneficiaries, refer to the user guides available at https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-and-training/fact-sheets.html, or contact the NCTracks Call Center at 800-688-6696. To reach the appropriate health plan for assistance with establishing or modifying panel size, please see the Provider Support Line information for each plan at https://medicaid.ncdhhs.gov/transformation/health-plans/health-plan-contacts-and-resources

HOW TO CHECK PATIENT ELIGIBILITY / PHP ENROLLMENT PRIOR TO LAUNCH?

The Recipient Eligibility Verification function of NCTracks has been modified to include the beneficiary's benefit program and managed care assignment information, and to allow providers to verify eligibility for the following month, as long as the beneficiary's eligibility segment extends into the following month. This means a provider will likely see the projected managed care enrollment status beginning in June. This is not a guarantee of NC Medicaid coverage or managed care assignment for the following month but will offer information as available at the time of the inquiry. Please always verify coverage and managed care assignment prior to rendering services.

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WHAT HAS CHANGED ABOUT THE NCTRACKS RECIPIENT ELIGIBILITY RESPONSE?

NC Medicaid Managed Care information has been added to the Recipient Eligibility Response page, including health plan name and contact information, as well as the health plan's assignment for PCP/AMH. Due to carve-out services and the necessity to display other benefit plan information, it is important for providers to give special attention to the Service Types and Copay section under each benefit plan.

Benefit Plan	What Does it Mean?
Medicaid (or NC Health Choice) 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 identifies the services covered and billed to the beneficiary's health plan.
Medicaid (or NC Health Choice) Managed Care Carve-out Plan	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 Mgmt (for CDSA Services), all of which would continue to be billed through Medicaid's fee-for-service program. See the Health Plan Contracts for more details on carved out services.
Managed Care for Behavioral Health Services	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.
Medicaid (or NC Health Choice) – FFS	Beneficiary remains in the NC Medicaid fee-for-service program for the dates specified. The Service Types and Copay section identifies the services covered and billed through Medicaid's fee-for-service program.

HOW TO VIEW YOUR PANEL (WITH EACH PHP) AFTER LAUNCH?

As described above, NC Medicaid will continue to post the Enrollee Report in the NCTracks Provider Message Inbox for NC Medicaid Direct and all health plans. AMH Tier 3s will receive their member list monthly through the 834/Beneficiary File. In addition, all AMHs/PCPs will receive assigned enrollee panel information from each health plan according to the table below:

AmeriHealth Caritas North Carolina (AMHC)	AMHC's secure provider portal at https://navinet.navimedix.com offers web-based solutions that allow providers and health plans to share critical administrative, financial and clinical data in one place. This tool can help you manage patient care with quick access to: • Panel roster reports • Member eligibility and benefits information • Care gap reports to identify needed services and preventive screenings • Member clinical summaries • Social determinants of health status • Admission and discharge reports • Medical and pharmacy claims data • Electronic submission of prior authorization requests.
Carolina Complete Health (CCH)	Providers may view their current member panel through the secure provider portal at https://network.carolinacompletehealth.com/. Information regarding panel management is provided during a provider's onboarding process.
Healthy Blue	Providers will be able to access panel reporting from Availity* or they can contact Provider Services (844-594-5072) and request a copy (*requires registration with Availity). Providers will be trained on how to pull panel reports from the Healthy Blue secure provider portal at https://www.availity.com/.
WellCare (WCHP)	WCHP's internal systems house panel management information and providers can reach out to their assigned Provider Network Specialist for confirmation of same. If the provider closes their panel to new members, they can view this in the WCHP online provider directory at https://provider.wellcare.com/
United Healthcare (UNHC)	Providers may sign-on to view their panel rosters electronically on the provider portal at https://www.uhcprovider.com/ , via a unique username and password.

HOW TO UPDATE YOUR PANEL WITH EACH PHP AFTER LAUNCH?

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. Information on updating panels can be found on AMHC's secure provider portal at https://navinet.navimedix.com/
Carolina Complete Health (CCH)	Providers may set their panel restrictions/limits at the point of contracting by populating the roster template panel column with their requested limitation. After contracting, if a provider wants to access their panel restrictions or see what was set, they can submit a request to the panel inquiry mailbox which is currently under development. If not specified at the point of contracting, the panel limit for an individual practitioner 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 at https://network.carolinacompletehealth.com/ .
Healthy Blue	Providers will not have closed panels, unless otherwise requested, and Healthy Blue will encourage provider collaboration should the need arise to limit their member panel. Healthy Blue requires providers to submit written notice at least 90 days prior to the effective date of closing the panel. The provider community will be educated on this process during upcoming Healthy Blue provider orientations and posted materials on Healthy Blue websites. More information on updating panels can be found on the Healthy Blue secure provider portal at https://www.availity.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 at https://provider.wellcare.com/

	Closing of Physician Panel: When requesting closure of the provider's panel to new and/or transferring WCHP Members, PCPs must: • Submit the request in writing at least 60 days (or such other period stated in the provider contract) prior to the effective date of closing the panel • Maintain the panel to all WCHP members who were provided services before the closing of the panel • Submit written notice of the reopening of the panel, including a specific effective date
United Healthcare (UNHC)	Providers are instructed to send a notice when panel modifications are needed. To update the PCP panels; • Go to UHCprovider.com. • Select Sign In on the top right. • Log in. • Click on Community Care.

WHAT MEMBER ID CAN I USE TO SEARCH FOR MY PATIENTS IN THE HEALTH PLAN PORTALS?

Health plans are required to allow providers to use the Member's North Carolina Medicaid or NC Health Choice Identification number to search in their health plan provider portals. Some health plans also allow providers to search by their patient's health plan member ID as well.

DO I NEED AUTHORIZATION 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 it 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 AND HOW LONG BEFORE THE CHANGE GOES INTO EFFECT?

Members should call the member services number for their assigned health plan on their back of their Medicaid cards and in their member handbook to change their primary care practice. Members can also call the enrollment broker for the first 30 days after managed care launch if they are also changing their health plan.

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 are encouraged to use their care management resources to help members with barriers to engage. PCPs should also work with their health plans to help members with barriers to engagement or to find a better PCP fit if all options have been exhausted.

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 NCTracks (https://www.nctracks.nc.gov) provider portal to verify your information and submit a MCR.

Fact Sheets will be updated periodically with new information. Updated June 2021.For more information, please visit https://www.ncdhhs.gov/assistance/medicaid-transformation