Fact Sheet
NC Medicaid Direct and NC Medicaid Managed Care/Nursing Facility - Local DSS Process

What counties need to know about the nursing facility process

FL-2 AND NURSING FACILITY LEVEL OF CARE AUTHORIZATION APPROVAL FORM

Required Documentation

DSS staff must receive one of the following to confirm a beneficiary meets nursing facility (NF) level of care:

- FL-2 (NC Medicaid Direct, found here) or:
- DBH-2039 Prepaid Health Plan (PHP) Notification of Nursing Facility Level of Care Form

Nursing Facilities should send a copy of the FL-2 (NC Medicaid Direct) / DHB-2039 "PHP Notification of Nursing Facility Level of Care" form to the appropriate local DSS **within five business days of receipt** of the documentation from NCTracks or the health plan.

Initiation of Processes

Once DSS is notified of the beneficiary's Nursing Facility admission, the following should begin:

- Long-term care financial eligibility determination
- Transfer of assets evaluation processes

How admission can be reported to DSS

- The "Change in Circumstance" (CIC) report
- Notification by Authorized Representative (A/R) or nursing facility
- Receipt of the FL-2 (NC Medicaid Direct) / "PHP Notification of Nursing Facility Level of Care" (DHB-2039) form.

Patient Monthly Liability

Upon notification of the Nursing Facility admission, DSS staff must determine the Patient Monthly Liability (PML) for non-MAGI members. Effective Sept. 1, 2025, MAGI members do not require a PML.

Eligibility Determination

If a MAGI member is expected to remain in the nursing facility over 90 consecutive days, the DSS should notify the business support team at medicaid.BusinessSupport@dhhs.nc.gov. In order for the MAGI member to be disenrolled from managed care the first day of the month following the month of the 90th consecutive day in the nursing facility. DSS staff **must use the initial** FL-2 (NC Medicaid Direct) / "PHP Notification of Nursing Facility Level of Care" (DHB-2039) form that includes the **initial date of admission** to the NF to determine eligibility.

If the NF has difficulty receiving the "PHP Notification of Nursing Facility Level of Care" (DHB-2039) form which documents NF level of care approval, DSS staff should contact the appropriate point of contact with the health plan.

Standard Plans

- **AmeriHealth Caritas**

  Prior Auth Fax Number: 833-893-2262

  Concurrent Fax Number: 833-894-2262

  ACNC UM Intake Fax Number: 800-900-2262

  Note: AmeriHealth Caritas is unable to accept clinical or case documentation by email (the process to upload information into their system supports provider portal or fax but not email submissions).

- **Healthy Blue**

  Provider Services 844-594-5072

  nc_provider@healthybluenc.com

- **Carolina Complete Health**

  Faith Samples, DSS Liaison faith.l.samples@carolinacompletehealth.com

  Julie Ghurtskaia JGhurtskaia@carolinacompletehealth.com

  Magalie Milfort Magalie.Milfort@CENTENE.com

- **United Healthcare**

  Angelina Rafferty angelina.rafferty@optum.com

  Bonnie Batten bonnie_w_batten@uhc.com

- **WellCare**

  Rhonda Frizzell, UM rhonda.frizzell@wellcare.com

  Yvonne Powers, CM yvonne.powers@wellcare.comp

  Lyndsey Zuccarello, UM lyndsey.zuccarello@wellcare.com

  SM_NC_CareCoordination@wellcare.com

Tailored Plans

- **Alliance Health**

  Provider Support 855-759-9700

Prior Authorizations, Notifications and Concurrent Review Fax Number 919-651-8691 or 919-651-8652

UMPhysicalHealthLeaders@alliancehealthplan.org

- **Partners Health Management**

  UM Physical Health Leadership umphysicalhealthleadership@partnersbhm.org

- **Trillium Health Resources**

  Benita Hathaway Benita.Hathaway@trilliumnc.org

  Monique B. Smith Monique.B.Smith@carolinacompletehealth.com

  Dawn Daly-Mack Dawn.DalyMack@carolinacompletehealth.com

- **Vaya Health**

  Missy Briones, UM Physical Health Clinical Director missy.briones@vayahealth.com

  Utilization Management Department UM@vayahealth.com

Children and Family Specialty Plan CFSP (Upon Launch)

- Healthy Blue Care Together

  Provider Services 844-594-5072

  nc_provider@healthybluenc.com

DSS ROLE IN DETERMINING NURSING FACILITY ELIGIBILITY

Health plans must report changes in beneficiary living arrangements to DSS. Living arrangement changes include, but are not limited to:

- Placement in Nursing Facility and
- Transitions from Nursing Facility ~~s~~ to hospitals or
- Transition from Nursing Facility to home

These changes are reported on the "Change in Circumstance" report and monitored in NC FAST. DSS must initiate a review of eligibility **within five days of a reported change.**

Once DSS is notified the beneficiary has been placed in a Nursing Facility, the financial eligibility determination process begins. To conduct the financial eligibility determination, DSS must receive the FL-2/ "PHP Notification of Nursing Facility Level of Care" (DHB-2039) form from the Nursing Facility. The long-term care financial eligibility determination timeline varies based on the information needed from the beneficiary, including asset verification and review of transfers of assets during the lookback period.

For members disenrolled from managed care due to a nursing facility stay return home, the DSS should notify the business support team at medicaid.BusinessSupport@dhhs.nc.gov. In order to end the exclusion from managed care due to the nursing facility stay.

For non-MAGI members:

- If a beneficiary is determined financially eligible for Nursing Facility care, DSS determines the Patient Monthly Liability (PML) amount for the beneficiary's cost of care and updates NC FAST.

- The PML is updated in NC FAST and sent to the health plans daily.

If a beneficiary is denied financial eligibility for NF care:

- DSS will send the denial notification to the member and/or authorized representative) and NC Medicaid at Medicaid.BusinessSupport@dhhs.nc.gov.
- The Medicaid Business Support team will notify the health plan of the denial.

NC MEDICAID DIRECT	NC MEDICAID MANAGED CARE
• FL-2/ Level of Care form submitted in NCTracks • NCTracks approves Level of Care and Nursing Facilities can review in NCTracks • NF sends the approved FL-2/ Level of Care form to DSS or DSS verifies in NCTracks • DSS begins the transfer of assets evaluation for all members • For non-MAGI members, DSS determines financial eligibility for nursing facility cost of care and authorizes coverage in NC • DSS enters the PML for non-MAGI members • For non-MAGI members, DSS sends "Notification of Eligibility for Medicaid/Amount and Effective Date of Patient Liability" form (NC Medicaid-5016) to the NF • For all members, DSS sends "DSS-8110 Your Medical Assistance Benefits Are Continuing, Changing, or Terminating" Notice of financial eligibility to the beneficiary • NF bills NF services to NC Medicaid Direct through NCTracks • DSS completes the transfer of assets evaluation • DSS sends the "DSS-8110 Your Medical Assistance Benefits Are Continuing, Changing, or Terminating" Notice to the beneficiary	• Nursing facility submits prior approval requests to the health plan • Health plan approves the prior authorization request and sends to the NF along with the "PHP Notification of Nursing Facility Level of Care" form (NC Medicaid-2039) • NF sends the completed "PHP Notification of Nursing Facility Level of Care" form (NC Medicaid-2039) to DSS • DSS begins the transfer of assets evaluation for all members • For non-MAGI members, DSS determines financial eligibility for nursing facility cost of care and authorizes coverage in NC • DSS enters the PML for non-MAGI members • For non-MAGI members, DSS Sends "Notification of Eligibility for Medicaid/Amount and Effective Date of Patient Liability" form (NC Medicaid-5016) to the NF • For all members, DSS sends "DSS-8110 Your Medical Assistance Benefits Are Continuing, Changing, or Terminating" Notice of financial eligibility to the beneficiary • NF bills the health plan for NF services until disenrollment from the health plan • DSS completes the transfer of assets evaluation • DSS sends the "DSS-8110 Your Medical Assistance Benefits Are Continuing, Changing, or Terminating" Notice to the beneficiary

NOTE: If the individual is found ineligible for financial eligibility for NF cost of care, NCTracks will deny the claims for NFs	**NOTE:** If the individual is found ineligible for financial eligibility for NF cost of care, the health plan will deny the claims for NFs

CHANGE IN CIRCUMSTANCE REPORT (CIC)

Health plans must report changes including a change in living arrangement to a NF, NF to hospital or NF to home on the "Change in Circumstance" report. DSS staff must work on the reports listed in the Medicaid Verification Tab under shortcuts. Refer to the job aid in NC FAST Help - "Change in Circumstance Report."

DSS staff should remember when determining the beneficiary's NF eligibility, they must use the initial NF level of care approval with the original date of admission received from the health plan.

WHAT DSS NEEDS TO KNOW

DSS staff should know the following information when determining a beneficiary's NF eligibility:

- Managed care status cannot be changed by DSS staff
- Managed care status responds to evidence entered in NC FAST and eligibility determinations
- DSS staff cannot manually change beneficiaries to NC Medicaid Direct
- The following process must be completed for a beneficiary to move to NC Medicaid Direct:
    - NF evidence entry > Beneficiary's Managed Care Status changes > Beneficiary returns to NC Medicaid Direct at the first of the month following the 90th consecutive day in the NF
- In DSS communication to NF staff, DSS can remind the facility these cases are treated as Medicaid Pending just like any other transfer to Long-term Care.

DSS staff should contact their Medicaid Operational Support Team (OST) representative for additional questions related to the NF eligibility determination process.