NC Medicaid Managed Care

Transition of Care Policy

North Carolina Department of Health and Human Services

Effective December 1, 2025

Contents

Background

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

An NC Medicaid beneficiary's transition between service delivery systems, including between health plans, poses unique challenges to ensuring continuity of service and effective coordination between responsible entities.

Transition of Care (TOC) activities applicable to NC Medicaid Managed Care are governed by regulatory and statutory requirements. The Department established its TOC requirements for Standard Plan in its *Request for Proposal 30-190029-DHB.*

The Department established its TOC requirements for Behavioral Health and Intellectual/Developmental Disabilities Tailored Plans in its *Request for Proposal 30-2020-052-DHB.*

The Department established its TOC requirements for Prepaid Inpatient Health Plans (PIHPs) in its *Request for Proposal 30-2022-007-DHB.*

Additionally, the Department established its TOC requirements for Child and Family Specialty Plan (CFSP) in its *Request for Proposal 30-2024-001-DHB.*

The term health plan will be used throughout this document to refer to Standard Plans, Tailored Plans, PIHPs, and the CFSP. The NCDHHS Transition of Care Policy aligns and supplements the requirements established in aforementioned contracts.

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 health plans. Accordingly, Medicaid beneficiaries are referred to as "beneficiaries."

Further, the Department has released 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 health plan contracts. Any conflict between this policy and a health plan contract shall be determined in favor of the contract.

Although health plans have the authority to delegate activities under this Policy to Advanced Medical Home Tier 3 (AMH Tier 3) / Clinically Integrated Networks (CIN), the health plan remains responsible for oversight to ensure delegated entities meet TOC requirements.

This Policy governs the health plan's practices related to TOC and includes the following TOC topics:

1. Ongoing Transition of Care

a. Policy statement for supporting beneficiaries to transition between health plans or between the health plan and another service delivery system, including disenrollment.

2. Transitional Care Management Requirements
    a. Appendix A: *Transition of Care at Crossover NC Medicaid Managed Care Launch*
    b. Appendix B: *Transition of Care: Special Considerations for Supporting Beneficiaries Who May Meet Tailored Plan Criteria*
    c. Appendix C: *Transition of Care Requirements for Service Determinations*
    d. Appendix D: *Transition of Care: Out-of-Network Provider Flexibilities for Newborn Care*

Policy Statement

General Transition of Care Requirements

a. The health plan shall develop policies, processes and procedures to support beneficiaries transitioning between health plans or between delivery systems.
b. The health plan shall identify enrolling or disenrolling beneficiaries, as defined in the NC Medicaid Managed Care Enrollment Policy, who are transitioning from or to another health plan, NC Medicaid Direct (including behavioral health services provided by Local Management Entity/Managed Care Organization [LME/MCO]), AMH Tier 3 or the Tribal Option.
c. For all beneficiaries transitioning from a health plan, the health plan shall transfer the information necessary to ensure continuity of care, including appropriate TOC data files and beneficiary-specific, socio-clinical information.
    i. The health plan shall facilitate the transfer of beneficiary's claims/encounter history and prior approval (PA) data between health plans and to other authorized Department Business Associates, as defined in 45 C.F.R. 160.103, following the data transfer protocols established by the Department and in accordance with related contract and privacy and security requirements. Transferred beneficiary-specific, socio-clinical information is also referred to as the beneficiary's transition file.
d. A beneficiary's transition file content may vary based on the beneficiary's circumstance but shall, at a minimum, include:
    i. The transitioning beneficiary's most recent care needs screening.
    ii. The transitioning beneficiary's most recent care plan (for transitioning care-managed beneficiaries and beneficiaries disenrolling from the managed care entity, if available).
    iii. A list of any open adverse benefit determination notices for which the appeal timeframe has not yet expired and the status of open appeals.
    iv. A TOC summary page for each beneficiary identified as meeting the high-need beneficiary criteria as defined in the Definition and Clarification of Identified Terms. This summary page includes minimally:
        i. List current providers.

ii. List of current approved services.

iii. List of current medications.

iv. Current diagnoses.

v. Known allergies.

vi. Existing or prescheduled appointments, including Non-Emergency Medical Transportation (NEMT), as known.

vii. Any urgent or special considerations about a beneficiary's living situation, caregiving supports, communication preferences or other beneficiary-specific dynamics that impact the beneficiary's care and may not be readily identified in other transferred documents.

v. Additional information as needed to ensure continuity of care.

e. The health plan shall transfer claims, PA and pharmacy lock-in data to the appropriate health plan or receiving entity in accordance with the applicable Transition of Care Data Specification Guidance.

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

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

h. Upon receipt of the relevant beneficiary information, the beneficiary's new health plan shall ensure all data as defined by the Department, once received, is transferred to the beneficiary's AMH Tier 3 or CIN on the timetables established in applicable AMH Data Specification Guidance.

i. The health plan shall ensure any beneficiary entering the health plan is held harmless by providers for the costs of medically necessary covered services except for applicable cost sharing.

j. The health plan shall allow a beneficiary to complete an existing authorization period established by their previous health plan, LME/MCO or NC Medicaid Direct.

k. The health plan shall assist the beneficiary in transitioning to an in-network provider at the end of the authorization period if necessary.

l. In accordance with N.C. Gen. Stat. §58-67-88(d)-(g), the health plan shall permit the beneficiary to continue seeing their provider, regardless of the provider's network status, in the following instances: a beneficiary transitions into a health plan from NC Medicaid Direct, another health plan or another type of health insurance coverage and the beneficiary is in an ongoing course of treatment or has an ongoing condition.

m. The health plan shall allow pregnant beneficiaries to continue to receive services from their behavioral health treatment provider, without any form of prior approval, until the birth of the

child, the end/loss of pregnancy or loss of eligibility.

Changes in Enrollment – DRG Claims

In instances where a beneficiary's enrollment changes (beneficiary changes between plans or between NC Medicaid Direct and a health plan) and there is no lapse in Medicaid coverage during a DRG-based inpatient stay, the plan assigned to the beneficiary on the "from" date of service is responsible for the entire DRG payment.

That plan is also responsible for the entire outlier payment. DRG and outlier payment calculations cannot be split and must consider the total number of days during the entire length of stay based on the DRG and the outlier payment methodology rules respectively for determining actual days to be paid.

Changes in Enrollment – Per-diem Inpatient Claims

In instances where a beneficiary's enrollment changes during a per-diem based stay, NC Medicaid Direct/the health plan is responsible only for the dates of service in which the beneficiary is enrolled with their plan. The provider should split the claim and bill the respective dates of service to the respective plans responsible for the dates of service in which the beneficiary was enrolled with their plan.

Health Plan Transition of Care Policy Content Requirements

The health plan shall establish a written health plan 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 beneficiaries who have an ongoing condition.

b. Coordination of beneficiary transition from NC Medicaid Direct into the health plan.

c. Coordination of beneficiary transition from an LME/MCO into the health plan.

d. Coordination of beneficiary transition from the Tribal Option into the health plan.

e. Coordination of beneficiary transition from the health plan into NC Medicaid Direct, LME/MCO or Tribal Option.

f. Coordination of beneficiary transition from the health plan to another health plan.

g. Coordination of transition for beneficiaries in the Management of Inborn Errors of Metabolism (IEM) Program, as defined in the health plan's contract.

h. Coordination of services delivered under other sources of coverage including NC Medicaid Direct.

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

j. Educate a transitioning beneficiary's provider of changes to the beneficiary's enrollment.

k. Other requirements as outlines in this Policy.

Additional Transition of Care Requirements for Beneficiaries actively engaged in Care Management

The health plan's TOC Policy shall integrate processes and procedures to manage the transition of a beneficiary actively engaged in care management. Processes and procedures shall reflect the following expectations:

a. Coordinate a timely warm handoff if deemed necessary, by the health plan, for effective knowledge transfer or to ensure beneficiary continuity of care.

b. Engage in 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 beneficiary'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 health plan's contract (e.g., Long Term Services and Supports or LTSS) and as outlined in the NCDHHS TOC Policy.

Additional Requirements for Beneficiaries Disenrolling from Health Plans to NC Medicaid Direct (including LME/MCOs) or the Tribal Option

The health plan's Transition of Care Policy shall integrate processes and procedures for supporting beneficiaries disenrolling to NC Medicaid Direct (including to an LME/MCO) or the 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 beneficiary through the disenrollment process.

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

    i. Coordination of a warm handoff with the receiving entity based on timelines established in this Policy.

    ii. ADT-disenrollment follow-up with the receiving entity to confirm receipt of transition file and consult on transition-related issues.

    iii. Coordination with entities necessary to ensure beneficiary continuity of care upon disenrollment, including but not limited to:

        a) Coordination with appropriate assessment entities, as applicable, to ensure no disruption in the beneficiary's enrollment. This coordination is to include submission of the LTSS Disenrollment Form for individuals receiving LTSS services in the health plan

or members that are disenrolling due to Community Alternatives Program (CAP) enrollment, and

b) Inform the beneficiary's current Medicaid providers of the anticipated disenrollment.

Additional Requirements for Cell and Gene Therapy Access Model Beneficiaries

a. For Cell and Gene Therapy (CGT) Access Model Beneficiaries, the receiving entity must honor existing and active prior authorizations for sickle cell disease gene-therapy-related care and prescriptions on file with NC Medicaid Direct or approved by the disenrolling health plan until the end of the authorization period to ensure continuity of care.

b. The receiving entity shall allow a CGT Access Model Beneficiary to continue to have access to and shall cover medically necessary services furnished by their same sickle cell disease gene therapy providers for at least one year after receiving their gene therapy infusion.

c. For a period no less than five years following the date of State-selected Model Drug infusion, the receiving entity shall permit a CGT Access Model Beneficiary who has transitioned from another health plan or from NC Medicaid Direct to have access to, and shall cover medically necessary services furnished to the CGT Access Model Beneficiary by, a treatment center qualified to administer State-selected Model Drugs.

Transition of Care Requirements with Change of Providers

a. The health plan shall develop policies, processes and procedures to support beneficiaries transitioning between providers when a provider is terminated from the health plan's network.

b. In accordance with N.C. Gen. Stat. § 58-67-88(d), (e), (f), and (g), instances in which a provider leaves the health plan's network for expiration or non-renewal of the contract and the beneficiary is in an ongoing course of treatment or has an ongoing condition, the health plan shall permit the beneficiary to continue seeing their provider, regardless of the provider's network status.

c. In instances in which a provider leaves the health plan's network for reasons related to quality of care or program integrity, the health plan shall notify the beneficiary in accordance with this section and assist the beneficiary in transitioning to an appropriate in-network provider that can meet the beneficiary's needs.

Beneficiary Notification of Provider Termination

a. As per 42 CFR § 438.10(f)(1):

   i. The health plan shall provide written notice of termination of a network provider to all beneficiaries who received services from the terminated provider within six months immediately preceding the date of notice of termination.

   ii. The health plan shall provide written notice of termination of a network provider to beneficiaries within 15 calendar days of the provider termination, except if a terminated provider is an AMH/Primary Care Provider (PCP) for a beneficiary.

b. If a terminated provider is an AMH/PCP for a beneficiary, the health plan shall notify the beneficiary of the procedures for selecting an alternative AMH/PCP within seven calendar days.

c. The beneficiary will be assigned to an AMH/PCP if they do not actively select one within 30 calendar days.

d. If a terminated provider is an AMH/PCP for a beneficiary, the health plan shall validate the provider the beneficiary selects or is assigned to. within 30 calendar days of the date of notice to the beneficiary and notify the beneficiary of the procedures for continuing to receive care from the terminated provider and the limitations of the extension.

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

f. The health plan shall hold the beneficiary harmless for any costs associated with the transition between providers, including copying medical records or treatment plans.

g. The health plan shall establish a Provider TOC Policy which shall include processes and procedures for:

    i. Coordination of care for beneficiaries who have an ongoing special condition.

    ii. Coordination for beneficiaries discharged from a high-level clinical setting.

    iii. Coordination for beneficiaries seeing a provider that leaves the health plan's network.

    iv. Coordination for beneficiaries needing to select a new AMH/PCP after a provider termination.

    v. Other requirements as defined in this section.

Transitional Care Management

a. The health plan shall develop policies and procedures for Transitional Care Management consistent with the requirements and protocols provided or referenced in this Policy.

b. The health plan shall manage transitions of care for beneficiaries transitioning between health plans or between payment delivery systems. Care managers assisting beneficiaries through the transition, potential transition between health plans or between payment delivery systems, shall follow the requirements and protocols provided or referenced in this Policy.

c. The health plan shall manage transitions of care (defined as care transitions), for all beneficiaries moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, ED visits or adverse outcomes.

d. The health plan shall develop a methodology to identify beneficiaries at risk of readmissions and other poor outcomes. This methodology shall consider:

    i. Frequency, duration and acuity of inpatient, skilled nursing facility (SNF) and LTSS admissions or ED visits.

    ii. Discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment

center.

iii. Neonatal intensive care unit (NICU) discharges.

iv. Identification of patients by severity of condition, medications, risk score, healthy opportunities and other factors the health plan may prioritize.

e. As part of transitional care management provided to identified beneficiaries who are moving from one clinical setting to another, the health plan shall:

i. Contact the beneficiary's AMH/PCP and all other medical providers.

ii. Facilitate clinical handoffs.

iii. Obtain a copy of the discharge plan and verify with the beneficiary's care manager the beneficiary received and reviewed the discharge plan with the beneficiary and the facility.

iv. Ensure a follow-up outpatient and/or home visit is scheduled within a clinically appropriate time window.

v. Conduct medication management, including reconciliation and support medication adherence though beneficiary education.

vi. Ensure a care manager is assigned to manage the transition.

vii. Ensure the assigned care manager rapidly follows up with the beneficiary following discharge.

viii. Develop a protocol to determine the appropriate timing and format of such outreach.

f. The health plan 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.

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

h. As part of transitional care management, the health plan shall implement a systematic, clinically appropriate process with designated staffing for responding to certain high-risk ADT alerts, including:

i. Real-time (minutes/hours) response to notifications of ED visits (for example, contacting the ED to arrange rapid follow-up).

ii. Same-day or next-day outreach for designated high-risk subsets of the population, such as children with complex health care needs admitted to the hospital.

iii. 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).

Definition and Clarification of Identified Terms

Term	Definition
Care Transitions	The process of assisting a beneficiary with the transition to a different care setting or through a life stage that results in or requires a modification in services (e.g., school-related transitions).
Cell and Gene Therapy (CGT) Access Model Beneficiary	A Cell and Gene Therapy (CGT) Access Model Candidate Beneficiary who meets all the following criteria: • Received an infusion of a State-Selected Model Drug (LYFGENIA or CASGEVY). • Has NC Medicaid as the beneficiary's primary payer for the infused State-selected Model Drug. • On the date the beneficiary is infused with the State-selected Model Drug, a value-based payment supplemental rebate agreement between the Department and the manufacturer of the infused State-Selected Model Drug is in effect; and • If the beneficiary is enrolled in a health plan or NC Medicaid Direct on the date the beneficiary is infused with the State-selected Model Drug.
Crossover Population	NC Medicaid beneficiaries enrolled in NC Medicaid Direct who 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 which includes a broad selection of preventive, diagnostic and treatment services. The EPSDT benefit 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)
High-need Beneficiary (for the purposes of TOC)	Individuals requiring time sensitive, beneficiary-specific follow up by the health plan. High-need beneficiaries include, but are not limited to, beneficiaries who are receiving or authorized to receive the following services: 1. High-need subset of beneficiaries receiving LTSS. a. Beneficiaries receiving or authorized to receive private duty nursing services who have also experienced one or more

Term	Definition
	ED visits or hospitalizations within 30 calendar days of transition. b. Beneficiaries receiving or authorized to receive home health services who have also experienced one or more ED visits or hospitalizations within 30 calendar days of transition. c. Beneficiaries who received home infusion therapy services, with dates of service within 30 calendar days of transition. d. Beneficiaries who reside in a nursing facility for 30 calendar days or less at transition. e. Beneficiaries who are authorized for 80 or more hours a month of personal care services (PCS) or minors receiving PCS. 2. Beneficiaries receiving crisis behavioral health services within six months of transition. 3. Beneficiaries with Inborn Errors of Metabolism. 4. Beneficiaries who have complex treatment circumstances or multiple service interventions and necessitate a warm handoff, identified by the health plan. 5. Beneficiaries who are experiencing a care transition from a high-level clinical setting. 6. Identified Standard Plan-exempt beneficiaries who elected to enroll in a Standard Plan. 7. Beneficiaries authorized for a transplant procedure. 8. Beneficiaries authorized for out-of-state services. 9. Beneficiaries with an approved authorization for a State-selected Model Drug (LYFGENIA or CASGEVY). 10. CGT Access Model Beneficiaries who have received an infusion of a State-selected Model Drug (LYFGENIA or CASGEVY) within the last five years. 11. Other high-need beneficiaries or group of beneficiaries identified by the Department or the health plan.
LME/MCO	LME/MCOs are public managed care organizations that provide comprehensive behavioral health services under the NC 1915(b) waiver for people in need of mental health, developmental disability or substance use services. LME/MCOs are regionally based.

Term	Definition
NC Medicaid Direct	North Carolina's health care program for Medicaid beneficiaries who are not enrolled in a health plan or EBCI Tribal Option. Beneficiaries in NC Medicaid Direct receive care management from two entities, Community Care of North Carolina (CCNC) provides care management for physical health services and four LME/MCOs coordinate services for mental health and substance use disorders, I/DD or TBI and Tailored Care Management (TCM).
Ongoing Course of Treatment	As defined in 42 C.F.R. § 438.62(b), when a beneficiary, 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 health plans when assisting designated disenrolling populations through the transition between payers. Protocols identify the receiving entity for each population and provide interventions to help ensure continuity of care. The Department has established protocols to assist beneficiaries who are disenrolling due to Medicare eligibility, foster care enrollment, 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 beneficiaries.
Receiving Entity	The entity that is enrolling the transitioning beneficiary and receiving the beneficiary's TOC data files and other related enrollment information.
Transferring Entity	The entity that is disenrolling the transitioning beneficiary and transferring the beneficiary's TOC data files and other related enrollment information.

Term	Definition
Transition of Care	The process of assisting a beneficiary in the transition between health plans or between payment delivery systems, including transitions that result in the disenrollment from managed care. Transitions of care also include monitoring a beneficiary in the transition between providers upon a provider's termination from the health plan's 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 plan(s). 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 monitoring a beneficiary's transition between health plans or to other payment delivery systems, including transitions that result in the disenrollment from managed care. Transitions of care also includes the process of monitoring a beneficiary in the transition between providers upon a provider's termination from the health plan's provider network.
Transitional Care Management	Management of beneficiary needs during transitions of care and care transitions (e.g., from hospital to home).
Warm Handoff	Time sensitive, beneficiary-specific planning for beneficiaries identified by either the transferring or receiving entity but at a minimum include: 1. Transitioning care-managed beneficiaries for whom the health plan deems a warm handoff necessary to ensure continuity of care 2. Beneficiaries disenrolling due to Medicare eligibility, foster care eligibility, facility admission that results in disenrollment and beneficiaries disenrolling due to LME/MCO service eligibility 3. Beneficiaries with an approved authorization for a State-selected Model Drug (LYFGENIA or CASGEVY) and CGT Access Model Beneficiaries who have received an infusion of a State-selected Model Drug (LYFGENIA or CASGEVY) within the last five years. Warm handoffs require collaborative transition planning between both transferring and receiving entities and if possible, occur prior to the transition. For additional information on high-needs beneficiaries requiring warm hand-off see appendix A.

Compliance and Monitoring

The Department shall monitor health plan transition of care activity through reporting requirements specified in Standard Plan, Tailored Plan and Children and Families Specialty Plan contracts 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

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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.*

Version	Posting Date	Summary of changes
1.2	6/1/2022	Updated Policy to: • Include Tailored Plan language
1.3	1/1/2023	Updated Policy to: • Change Policy section III 3. b) (4) to clarify TOC Summary is required for high-needs beneficiaries requiring a warm handoff. • Updated Appendix A to indicate high needs beneficiaries and warm hand offs apply to both Crossover and ongoing transitions • Update Tailored Plan effective date from Dec 1, 2022, to April 1, 2023 • Added PIHP in definitions • Include PIHP in “IV. Definitions and Clarification of Identified Terms”
1.4	3/8/2023	Updated Policy to: • Clarify responsible party for DRG and per-diem inpatient claims when there is an enrollment change
1.5	3/13/2023	Updated Policy to: • Remove reference to PIHP and replace with LME/MCO or NC Medicaid Direct
2.0	12/1/2025	Updated Policy to: • Incorporate Cell and Gene Therapy transition of care details • Incorporate CFSP, added where applicable • Removed of TP references where applicable • Removed all Footnotes • Updates to High Needs references • Overall document cleanup for clarity

Appendix A – Transition of Care at Crossover

Overview

Beneficiary transitions between health plans and/or service delivery systems are collectively referred to as Transition of Care. The Department has recognized that Transition of Care involves two distinct phases:

- Crossover
- Ongoing Transition of Care

As beneficiaries move between delivery systems, the Department expects processes will be in place that ensure continuity of care for each beneficiary and minimize the burden on providers during the transition. Recognizing the specific dynamics and needs of high-need beneficiaries that the Department has established requirements of the health plans in Appendix A of the TOC Policy.

Applicable Definitions

Crossover: The timeframe immediately before and after the implementation date of any NC Medicaid Managed Care plans or programs in the applicable region. Crossover-related requirements, flexibilities, 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 any NC Managed Care health plan benefit, initiated prior to NC Medicaid Managed Care launch, and evidenced by a current treatment plan, which is related to a beneficiary's condition or circumstance and is provided to the beneficiary by the non-participating provider within the first 60 days after NC Medicaid Managed Care launch.

High-need Beneficiary (for purposes of Transition of Care): Individuals requiring time-sensitive, beneficiary-specific follow up by the health plan. High-need beneficiaries include, but are not limited to, beneficiaries who receive or are authorized to receive the following services:

1. High-need subset of beneficiaries receiving LTSS.
    a. Beneficiaries 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.
    b. Beneficiaries 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.
    c. Beneficiaries who receive home infusion therapy services, with dates of service within 30 days of NC Medicaid Managed Care launch.
    d. Beneficiaries who enrolled in a nursing facility for 30 calendar days or less at NC Medicaid Managed Care launch.
    e. Beneficiaries authorized for 80 or more hours a month of PCS or minors receiving PCS.
2. Beneficiaries receiving crisis behavioral health services within six months of NC Medicaid Managed Care launch and/or Tailored Plan launch.

3. Beneficiaries with Inborn Errors of Metabolism.
4. Beneficiaries identified by CCNC, AMH Tier 3's, an LME/MCO or the Department who have complex treatment circumstances or multiple service interventions and necessitate a warm handoff.
5. Beneficiaries experiencing a care transition from a high-level clinical setting.
6. Identified Standard Plan-exempt beneficiaries who elected to enroll in a Standard Plan.
7. Beneficiaries authorized for a transplant procedure.
8. Beneficiaries authorized for out-of-state services.
9. Beneficiaries with an approved authorization for a State-selected Model Drug (LYFGENIA or CASGEVY).
10. CGT Access Model Beneficiaries who have received an infusion of a State-selected Model Drug (LYFGENIA or CASGEVY) within the last five years.
11. Other high-need beneficiaries or group of beneficiaries identified by the Department or the health plan.

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 or a new Managed Care plan is launched (e.g., Tailored Plan launch, CFSP launch, etc.). This date is also referred to as implementation.

Warm Handoff is required for a subset of high-needs beneficiaries, to provide beneficiary-specific meeting/knowledge transfer session(s) between transferring entity and receiving entity. Beneficiaries requiring a warm handoff may be identified by either the transferring or receiving entity.

Crossover Follow-up Direct contact with the identified beneficiary/authorized representative to confirm continuity of services; to provide any beneficiary-specific health plan contact information directly to the beneficiary/authorized representative and to address any crossover-related issues the beneficiary may be experiencing. Health plans shall prioritize follow-up activity with high-need beneficiaries based on urgency of need but should strive to conduct follow-up with identified high-need beneficiaries no later than three weeks following any NC Medicaid Managed Care launch.

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

Crossover Requirements: Data Transfer and Health Plan Acceptance of Data Files

Requirements

- Health plans 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.

- Health plans have the capacity to accept, ingest and use service assessment and care plan detail available to the health plan.
- Health plans 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:
- Provide information about the health plan's prior authorization process for inclusion in the Department sponsored Health Plan PA Resource webpage.
- Establish 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 Beneficiary Supports and Services

Requirements

- Health plans participate in beneficiary-specific knowledge transfer sessions known as warm handoffs for beneficiaries identified by either transferring entity or by the health plan. Warm handoffs will begin three weeks prior to NC Medicaid Managed Care launch and/or Tailored Plan launch and are to be completed no later than one week after launch.
- Health plans provide expedited follow-up after NC Medicaid Managed Care launch and/or Tailored Plan launch with high-need beneficiaries as defined within this Appendix to:
    - Ensure identified services continued without disruption.
    - Initiate post-NC Medicaid Managed Care launch assessments that may be required to evaluate the beneficiary's continuation of services after 90 days.
    - Ensure uninterrupted access to NEMT.
- Health plans provide high-need beneficiary 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

Health plans accept requests for NEMT appointment(s) for post-NC Medicaid Managed Care launch from eligible beneficiaries no later than one month prior to NC Medicaid Managed Care launch.

Crossover Requirements: Honoring Existing and Active PAs Post-NC Medicaid Managed Care Launch

Requirements

- To ensure continuity of care for beneficiaries, the health plan must honor existing and active medical PAs on file with NC Medicaid 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 health plan shall deem authorizations submitted directly by impacted providers as covered under this requirement.
- NC Medicaid Direct Utilization Management Vendors and 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 health plan may receive additional NC Medicaid Direct PAs on the incremental PA transfer file after NC Medicaid Managed Care launch and/or Tailored Plan launch. The health plan shall honor NC Medicaid Direct 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 NC Medicaid Direct PAs.
- For new PA requests submitted by providers to the health plan on or after NC Medicaid Managed Care launch and/or Tailored Plan launch, standard utilization management requirements and allowances as specified in the health plan contracts apply. New PA requests submitted by providers to the health plan may include requests for reauthorization of services initially authorized by NC Medicaid Direct.
- Health plans are strongly advised to consider the beneficiary's prior service history and prior clinical circumstance when reviewing new PA requests, including reauthorization requests, during the crossover time.

Crossover Requirements: Health Plan Payment of Services in Place at Crossover

Requirements

- Generally, health plans 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, health plans 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 beneficiary has an ongoing special condition or is under an ongoing course of treatment. In these circumstances, the health plan shall follow the timeframes provided in N.C. Gen. Stat. § 58-67-88(d), (e), (f), and (g).
- For Medicaid beneficiaries who are admitted to an acute care facility and eligible for full NC Medicaid Direct 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 health plan contract, health plans 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 beneficiaries 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. Health plans are otherwise required to adhere to Clinical Coverage Policy 8C, *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers.*

Crossover Requirements: Health Plan Governance Processes

Requirements

- The health plan's TOC Policy shall reflect how the health plan will monitor the implementation and ongoing activity related to the requirements identified in the Appendix.
- The health plan 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 processes related to data transfer issues and beneficiary disruption in care.
- Complete and submit crossover status reports and data reconciliation detail as outlined in the Crossover Requirements: Reporting section of the Appendix.

Crossover Requirements: Reporting

Requirements

- The health plan shall participate in file transfer, data reconciliation processes and reporting as identified by the Department.
- The health plan shall provide status reports on engagement activities and service disposition of high-need beneficiaries.
- The health plan will track and have the capacity to report and reconcile beneficiary-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: Beneficiary and Provider Education

The Department will not require formal call center scripts for crossover-specific dynamics. The Department will establish crossover-specific “talking points” and the health plan will incorporate into its Call Center protocols and staff training, providing additional training to the health plans as needed. The Department will finalize these talking points and require health plans 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 beneficiary’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 beneficiaries on pre-NC Medicaid Managed Care launch scheduling of post-NC Medicaid Managed Care launch NEMT appointments.
- Guidance to beneficiaries 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 beneficiary continuity of care and provide clarity on applicable crossover processes.

Crossover Requirements: Crossover-Specific Considerations for Adverse Determination

Generally, health plan activity is governed by *Beneficiary Grievances and Appeals* section of Revised and Restated RFP.

The health plan and the Department shall follow any resulting order by the Office of Administrative Hearings (OAH) or another court.

Appeals-related Considerations at Crossover

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 p.m. 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 health plan shall honor for the duration of the authorization or 90 days after NC Medicaid

Appeals-related Considerations at Crossover
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 Maintenance of Service (MOS) is in effect for a beneficiary at NC Medicaid Managed Care launch, for a service covered by the health plan, the health plan is financially responsible for post-NC Medicaid Managed Care launch services provided under MOS until the health plan 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 Beneficiary who Transfers to the Health Plan (NEW) • If MOS/COB is for service *not* covered by the health plan and the beneficiary has voluntarily, proactivelytransferred from an LME/MCO to a health plan (Standard Plan Exempt), the beneficiary has waived MOSupon transfer. • If MOS/COB is for service that is covered by the health plan, MOS protocol outlined in the MOS Requirement applies.
Position Statement: Retroactive PA Requests If a provider submits a *retroactive* PA covering the health plan 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 appropriateauthorizing entity. • If the receiving entity reviews and denies the portion of the request within its authority, it must also issue appeal rights.
Requirement: Health Plans honoring FFS PAs after NC Medicaid Managed Care Launch and/or Tailored Plan Launch The health plan must honor open PAs for the 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.

Appeals-related Considerations at Crossover
Requirement: Appeal Rights on Terminated or Reduced pre-NC Medicaid Managed Care Launch and/or Tailored Plan Launch Authorized Services. If a health plan terminates/reduces an -authorized service after 90 days, the health plan must issue appeal rights. A health plan 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 Beneficiary Grievances and Appeals section of Revised and Restated RFP. Related Reporting Requirement: health plan's adverse determination on an authorized service should be uploaded into the Medicaid Appeals and Grievance Clearinghouse.

Appendix B – Transition of Care: Special Considerations for Supporting Beneficiaries Who May Meet Tailored Plan Enrollment Criteria

Overview

This Appendix establishes the Department's requirements of Standard Plans to assist in transitioning beneficiaries who are eligible for Tailored Plans,

Specifically, this Appendix includes requirements related to supporting:

- Standard Plan beneficiaries who are not required to enroll in the Standard Plan because of Tailored Plan eligibility, but elect to do so; and
- Standard Plan beneficiaries 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:

- NC Medicaid Managed Care Final Policy Guidance on Behavioral Health and Intellectual/Developmental Disability Tailored Plan Eligibility and Enrollment (Final Policy Guidance) and related updates.
- 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).
- In accordance with related legislation.

Definitions

Behavioral Health I/DD Tailored Plan: Tailored Plans are specialized managed care products targeting the needs of individuals with behavioral health disorders, substance abuse disorders, intellectual and developmental disabilities (I/DD), and traumatic brain injuries (TBI). These plans launched July 1, 2024. Individuals meeting Tailored Plan eligibility criteria are enrolled in a Tailored Plan

Tailored Plan Eligibility Request Process: The process was established to support Standard Plan enrolled beneficiaries 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

Overarching Expectation of Support for Beneficiaries Who May Meet Tailored Plan Criteria

A Standard Plan and/or CFSP shall effectively provide behavioral health support to its beneficiaries, which include ensuring that its beneficiaries have access to clinically indicated behavioral health services within the health plan's scope. If a beneficiary requires services or interventions available only through the Tailored Plan, the Standard and/or CFSP shall support the beneficiary to understand

the service options available and assist the beneficiary through any subsequent transition to the Tailored Plan.

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

NCDHHS Policy Positions and Requirements

- Medicaid beneficiaries identified as eligible for Tailored Plans will have the option to enroll in a Standard Plan. Beneficiaries who are eligible for a Tailored Plan but choose to enroll in a Standard Plan will be identifiable on the 834 Eligibility File. Tailored Plan eligible beneficiaries who remain in or return to the Standard Plan shall be designated by the health plan as a priority population for Care Management under the Adults and Children with Special Healthcare Needs category.
- To ensure access to necessary services, the Department established the following pathways for identifying Standard Plan or CFSP beneficiaries who may be more appropriately served under the Tailored Plan:
    - Beneficiaries identified through the Department Claim and Encounter Review.
    - Beneficiaries identified through the Behavioral Health I/DD Tailored Plan Eligibility Request process.
    - Beneficiaries who experience other qualifying events, as reflected in the Tailored Plan eligible definition within this Appendix.
- The Standard Plan and CFSP shall follow protocols set by the Department related to identifying, reporting and assisting applicable beneficiaries who may be more appropriately served under the Tailored Plans.
    - To assist beneficiaries who may be eligible for Tailored Plans, the health plans 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 health plans shall establish internal policies and procedures for assisting beneficiaries who may be eligible for Tailored Plans. At a minimum, these policies and procedures shall be aligned with health plans' 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 Appendices in this Policy.
        - Internal operational processes for coordinating with Department on supporting the transition of beneficiaries identified for disenrollment due to Tailored Plan eligibility.
- If a beneficiary age 21 or under is enrolled in a Standard Plan and/or CFSP who needs a service that is only available in the Tailored Plans, and the service meets the requirements for EPSDT, the Standard Plan or CFSP must cover that service for any period the beneficiary is enrolled with that health plan. 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.

- The Standard Plan and/or CFSP shall report on activities related to identifying, reporting and assisting Tailored Plan eligible beneficiaries, in a manner specified by the Department.
- For all beneficiaries referenced in this Appendix who transition to an LME/MCO or a Tailored Plan, Transition of Care requirements, as specified in the health plan's contract and the TOC Policy apply.

Appendix C – Transition of Care Requirements for Service Determinations

Overview

When an adverse determination occurs due to a beneficiary's transition, the health plan shall adhere to the following requirements:

- Generally, health plan appeals, and State Fair Hearings (SFH) activity are governed by the *Member Grievances and Appeals* section of the health plan's contract.
- The health plan and the Department shall follow any resulting order by the Office of Administrative Hearings (OAH) or another court.
- As specified in this Policy, the health plan will communicate the status of any open, adverse benefit determinations and related appeals and SFH as part of its transition file content.
- The health plan and the Department must adhere to all applicable state and federal requirements.
- EPSDT may alter the positions established in this Appendix.

Requirements for When a Beneficiary Transitions Between Health Plans

- PA Requests submitted prior to the beneficiary's transition.
    - If a PA request is submitted prior to the beneficiary's transition date, the beneficiary's current health plan will review and adjudicate the PA request and send open/active PA to the receiving entity in accordance with the TOC data specification requirements.
    - For initial requests with a requested start date prior to the transition, the health plan will review and either approve or make an adverse determination with appeal rights.
- If the beneficiary's appeal with the originating health plan remains open when the beneficiary transitions, the appeals process continues through the originating health plan. The originating health plan may be unable to render a determination due to the dates of service requested. If unable to render a determination, the originating health plan will communicate its position through a Notice of Decision/Resolution with SFH appeal rights. The originating health plan will include in its communication instructions to resubmit the request to the beneficiary's new health plan.
- If the SFH is live at transition, the appeals process continues although the originating health plan may not have the authority over the beneficiary's services. The originating health plan will communicate its position through the SFH process and will direct the beneficiary to resubmit the request to beneficiary's new health plan.
- For initial requests with a requested start date occurring after the beneficiary's disenrollment from the health plan to another health plan or to NC Medicaid Direct (e.g., the entire required authorization period occurs after the beneficiary's transition to new the health plan or to NC Medicaid Direct) that is submitted after the known transition date (Notice Date), the current health plan is not required to process but must issue its unable to process notice to the beneficiary and communicate this position to the provider.

- For initial requests submitted with start date after the beneficiary's Medicaid eligibility ends, the health plan shall review and process the request based on medical necessity, in the event the beneficiary's Medicaid eligibility is extended. Payment by the health plan for services rendered may be contingent on the beneficiary's managed care enrollment status on the date of service.
- For a request for reauthorization of service[17] with requested reauthorization date prior to the transition, the health plan will review the full date span and either approve or make an adverse determination with appeals rights.
- If, at or after the transition, a beneficiary has timely requested COB the beneficiary's new health plan must continue benefits at the originally authorized level until it reassesses the beneficiary and renders its own determination or until the end of benefit authorization period, whichever occurs first.
- If, at transition, a beneficiary is within the timeframe to request COB, the beneficiary's new health plan must continue benefits at the originally authorized level until the end of the COB request timeframe.
- If, at transition, a beneficiary is within the timeframe to request COB, the beneficiary's new health plan must continue benefits at the originally authorized level until the end of the COB request timeframe.
- If, after transition, the beneficiary's new health plan, upon reassessing the beneficiary, also chooses to reduce or terminate the benefit, the new health plan must issue a Notice of Adverse Benefit Determination with appeal rights and a new COB timeframe. If the beneficiary appeals and timely requests COB under the new timeframe the beneficiary will retain the original level of authorized service until the appeal is resolved.
- If the beneficiary's appeal with the originating health plan is live at transition, the appeal process continues, though the originating health plan may be unable to render a determination due to the dates of service requested. If unable to render a determination, the originating health plan will communicate its position through a Notice of Decision/Resolution with SFH appeal rights. The originating health plan will include in its communication: the beneficiary's benefits have transferred to the new health plan and restate the State's expectations that COB, timely requested, will be maintained by the beneficiary's new health plan until the new health plan reassesses and makes a determination.
- If the SFH is live at transition, the appeals process continues, though the originating health plan may not have authority over the beneficiary's ongoing services. The originating health plan will communicate its position through the SFH process. Through the SFH process, the originating health plan will also inform the beneficiary that benefits have transferred to the new health plan and restate the State's expectations that COB, timely requested, will be maintained by the beneficiary's new health plan until the new health plan reassesses and decides.
- For a request for reauthorization of service with the requested reauthorization date occurring after the beneficiary's disenrollment from the health plan (e.g., the entire requested reauthorization period occurs after the beneficiary's transition) that is submitted after the beneficiary's known transition date (Notice Date) the health plan is not required to process but must issue an unable to process notice to the beneficiary and communicate this position to the provider.

- In accordance with the Department's Transition of Care data transfer requirements, the current authorization will transfer to the beneficiary's new health plan. Upon transition, the beneficiary's new health plan will make its independent determination.
- Prior Authorizations Erroneously Submitted to a Beneficiary's Previous Health Plan for Service Dates on or after the Beneficiary's Transition
- If a PA request is submitted to a beneficiary's previous health plan after the beneficiary's transition date, the beneficiary's previous health plan will reject the PA unreviewed and redirect the submitter to the beneficiary's current health plan.
- This rejection does not trigger appeal rights.
- Retroactive Prior Authorization Submitted to the Beneficiary's Previous Health Plan for Dates of Service the Beneficiary was enrolled with Previous Health Plan
    - Excluding DRG-based services, the beneficiary's previous health plan shall review the retroactive PA request for dates when the beneficiary was enrolled.
- If not approved, the beneficiary's health plan must issue a notice of adverse benefit determination with appeal rights for dates of service within its coverage span.
- Appeals of Involuntary Disenrollment from Health Plan
- A beneficiary who has experienced a health plan-initiated involuntary disenrollment may appeal the determination following processes established in the health plan contract.
- The health plan will follow applicable transition of care requirements for beneficiaries transitioning due to involuntary disenrollment and due to the outcome of related appeals.

Requirements When a Beneficiary is Disenrolling to NC Medicaid Direct (including an LME/MCO)

- For beneficiaries disenrolling to NC Medicaid Direct, including to an LME/MCO, the health plan shall follow requirements for processing Initial Requests established under *Requirements when a Beneficiary Transitions Between Health Plans* section of the Appendix.
    - If the health plan's adverse determination is made with COB rights, the health plan COB timeframe of 10 days applies, even if the beneficiary is transitioning to NC Medicaid Direct.
- For service authorization requests erroneously submitted to the health plan after the beneficiary's transition, the health plan shall follow requirements for erroneous submissions established under *Requirements when a Beneficiary Transitions Between Health Plans* section of this Appendix.

When Disenrollment to NC Medicaid Direct Results in a Reduction in Services Authorized by the Health Plan

- As a general policy, hours or units remaining for a service authorized by a health plan and covered by NC Medicaid Direct will transfer with the transitioning beneficiary up to the NC Medicaid Direct benefit limit.
- If a beneficiary 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

Overview

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