NC Medicaid Managed Care
Provider Playbook

NC Medicaid

Fact Sheet

What Providers Need to Know Part 2: After Tailored Plan Launch

Post-launch Checklist and Information

Behavioral Health and Intellectual/Developmental Disabilities (I/DD) Tailored Plan (Tailored Plans) launched July 1, 2024. A small percentage of Tailored Plan eligible beneficiaries will remain in NC Medicaid Direct. This fact sheet supplements the What Providers Need to Know Part 1 fact sheet and provides additional information providers need to know following the launch of Tailored Plans.

KEY DATES

- **July 1, 2024**: Tailored Plan launch
- **Sept. 30, 2024:** Final date Tailored Plans will relax medical prior authorization (PA) requirements. Tailored Plans must honor existing and active medical PAs on file with NC Medicaid (or until the end of the authorization period, whichever occurs first), except for a member engaged in an ongoing course of treatment as defined by N.C.G.S. § 58-67-88(d)-(g).

  For members engaged in an ongoing course of treatment, PAs and provider payment flexibilities will continue until Jan. 31, 2025, or until the member opts to discontinue the services or selects to receive services from a different provider.
- **Sept. 30, 2024:** Final date Tailored Plans will relax pharmacy PA requirements. Tailored Plans must honor existing and active pharmacy PAs on file with NC Medicaid Direct through the end of the authorization period.
- **Sept. 30, 2024:** Last date to submit claims for Medicaid-enrolled out-of-network providers that will pay equal to in-network providers.
- **Jan. 31, 2025:** Last date to submit claims for Medicaid-enrolled out-of-network providers that require authorizations equal to in-network providers.
- **Jan. 31, 2025:** Last date Tailored Plans must offer a member's out-of-network PCP a contract or single case agreement to allow members to keep their current PCP.
- **Jan. 31, 2025:** Expiration date for PAs and provider flexibilities for medically necessary services for members in an ongoing course of treatment as defined by N.C.G.S. § 58-67-88(d)-(g).

KEY REMINDERS FOR PROVIDERS

All providers are strongly encouraged to complete the following checklist after Tailored Plan launch.

- Make sure your office staff know with which health plans you are contracted.
- Continually review the NCTracks provider record for each applicable individual provider and organization for accuracy. If changes are needed, submit using the Manage Change Request (MCR) process. Changes must be reported within 30 calendar days.
- Know where to submit claims based on the member's enrollment on the date the service is rendered.
- For each health plan under contract, be sure enrollment in the health plan's electronic funds transfer program is complete.
- Assist members with the transition to Tailored Plans.

PROVIDER CONTRACTING REMINDERS

Health plan contracting is an ongoing process. There are consequences for non-participation impacting both providers and members. For example, NC Medicaid Managed Care members must select or be assigned to a PCP from their health plan's in-network providers. Health plans auto-assign members to providers in their network if a member does not select an in-network PCP.

Until Jan. 31, 2025, Tailored Plans are required to offer a member's out-of-network PCP a contract or single case agreement to allow the member to continue seeing the PCP.

NC Medicaid strongly encourages providers, especially PCPs and Advanced Medical Homes (AMHs), to work with Tailored Plans to meet contracting deadlines to support service continuity for members.

For more information on contracting with a health plan, contact the plan directly. Contact information is located on the Medicaid website at Health Plan Contacts and Resources Page.

MAKE SURE INFORMATION IS CORRECT

NC Medicaid providers are contractually required to update their NCTracks record within 30 days of any change.

The obligation to report includes any change in information contained in the NCTracks provider enrollment record, as well as any adverse action against the provider or any of its officers, agents or employees.

To remain compliant and ensure accurate information is supplied to health plans and members, providers should regularly review their provider record in NCTracks. Changes may be submitted using the MCR process available in the NCTracks Secure Provider Portal. Health plans can only update certain information in their files upon receipt of the information from NCTracks.

Review the NC Medicaid Provider Administrative Participation Agreement here or a recent publication about reporting changes here.

Confirm individual providers are correctly affiliated to all organizations billing on their behalf and to each appropriate location within the organization. This is done through a review of the individual provider's NCTracks record and is essential to ensure provider directories display accurate results.

Information will be displayed in the Medicaid Provider and Health Plan Lookup Tool. When a member searches for an individual doctor at a specific organization's location, the affiliated information from NCTracks is used in the search. Therefore, all individual providers should check their affiliations not only to the group NPI, but also to the specific location(s) where services are rendered.

KNOW HOW TO SUBMIT CLAIMS

Claims for dates of service prior to July 1, 2024, should be submitted as they are today, through NCTracks or to LME/MCOs for behavioral health services. A limited set of services are carved out of NC Medicaid Managed Care and should continue to be billed through NCTracks even after Tailored Plan launch.

These include dental services, eyeglasses and Child Development Services Association (CDSA) included on an Individualized Family Service Plan (IFSP) provided by independent practitioners. Review the benefits and services all plans offer, and the benefits and services carved out of health plans here.

For dates of service July 1, 2024, and after, claims routing depends on a member's enrollment at time of service and the services provided.

Claims for beneficiaries enrolled in NC Medicaid Direct should continue to be submitted to NCTracks or LME/MCO for behavioral health services.

Claims for members enrolled in a Tailored Plan should be submitted as instructed by the assigned health plan shown on the member's health plan ID card and validated through NCTracks Recipient Eligibility Verification methods, unless the service provided is a carved-out service.

Two "Claims Submission" provider fact sheets are available in the Provider Playbook to address how managed care claims are filed.

ASSIST MEMBERS WITH THE TRANSITION

It is important all office staff know the health plans with which providers are contracted and take the initiative to assist patients with the transition to NC Medicaid Managed Care.

- Tailored Plan members can change their PCP at any time without cause through Jan.31, 2025. Members can choose a different PCP from the one they were auto-assigned May 16, 2024. After Jan. 31, 2025, members can change their PCP once a year without cause and as often as needed with casue.
- Members should contact their health plan to change their PCP. Contact information is available on the Health Plan Contacts document in both English and Spanish.
- Members enrolled in a Tailored Plan receive a Member Welcome Packet, Member Handbook and health plan ID Card from their Tailored Plan. Follow these steps when a Tailored Plan member presents at your office:
    - Verify eligibility, PCP and health plan enrollment using the NCTracks Recipient Eligibility Verification/Response or by calling the NCTracks Automated Voice Response System (AVRS) at 800-723-4337.

      To avoid any confusion associated with newly issued health plan ID cards, providers and pharmacies should verify eligibility through NCTracks and not rely solely on the information shown on the member's health plan ID.

    - Health plans are required to generate a health plan ID card for members enrolled in their health plan. Member health plan ID cards are not required to be displayed to provide services at pharmacies to dispense medications. Therefore, members should not be turned away due to the lack of a health plan ID card in their possession.
- Confirm your office participates with the member's Tailored Plan.
- If you are not the assigned PCP for the member but are in-network for the Tailored Plan, you can render and be paid for primary care services.
- If the member would like to have you assigned as their PCP, they should call their health plan to change their PCP.
- If you are a non-participating provider for the member's Tailored Plan, you may render services. Special protection is afforded to non-network providers (see the Transition of Care section) during the transition period described above.

  If a good-faith contracting effort has been made by the health plan and you declined to contract with the member's health plan, you may be reimbursed 90% of the Medicaid rate. Good faith contracting requirements and information are available in the plan's policies.

TRANSITION OF CARE PROTECTIONS IMPACTING PROVIDERS

As a provider, it is important you are aware of the Transition of Care protections that impact providers.

- Tailored Plans are required to relax medical PA requirements and honor existing and active PAs on file with NC Medicaid Direct for services covered by the health plan through Sept. 30, 2024, or the end of the authorization period, whichever occurs first.
- Tailored Plans are required to relax pharmacy PA requirements through Sept. 30, 2024. Tailored Plans must honor existing and active pharmacy PAs on file with NC Medicaid Direct through the end of the authorization period.
- Tailored Plans will pay claims and authorize services until Sept. 30, 2024, for Medicaid-enrolled out-of-network providers equal to that of in-network providers.
- Until Jan. 31, 2025, the Tailored Plan will allow members to continue medically necessary services in an ongoing course of treatment (as defined by N.C.G.S. § 58-67-88(d)-(g).) until Jan. 31, 2025 or the end of the episode of care, whichever occurs first.
- If a member transitions between health plans after Aug. 1, 2024, a PA authorized by their original health plan will be honored for the life of the PA by their new health plan.
- For more information see the Transition of Care webpage on the NC Medicaid website.

WHAT IF MEMBERS HAVE QUESTIONS?

If members have questions about their health plan, want to change their PCP, AMH, TCM or have questions about services covered, they should contact their health plan.

Contact information for health plans can be found at the number on their health plan ID card or on Health Plan Contacts document in both English and Spanish.

Members who want to change their health plan should call the NC Medicaid Enrollment Broker at 833-870-5500, (TTY: 833-870-5588), 7 a.m. to 5 p.m., Monday through Saturday.

Beneficiaries can contact the NC Medicaid Ombudsman if they need help understanding NC Medicaid Managed Care or not able to resolve problems with their health plan or provider. Call 877-201-3750 or visit ncmedicaidombudsman.org.

WHAT IF I HAVE QUESTIONS?

Additional resources for providers on the transition to NC Medicaid Managed Care can be found in the NC Medicaid Help Center, the Provider Playbook and on the Medicaid Transformation website. The Day One Quick Reference Guide can also be found on the Provider Playbook Fact Sheet page.

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 published in the health plan's provider manual.

For questions related to NCTracks provider information, contact the NCTracks Call Center at 800-688-6696. To update your information, log onto the NCTracks Provider Portal to verify your information and submit an MCR. For all other questions, contact the NC Medicaid Contact Center at 888-245-0179.