Fact Sheet
What Providers Need to Know:
Part 2 – After Managed Care Launch

Post-Launch Provider Checklist and Information

The statewide launch of NC Medicaid Managed Care is **July 1, 2021**. A small percentage of beneficiaries will stay in NC Medicaid Direct. This fact sheet supplements the Part 1 fact sheet to offer more information providers need to know after managed care launch.

This fact sheet was updated in September of 2021 to incorporate the Nov. 30, 2021, extension for out-of-network provider payments and flexibility for prior authorization requirements.

KEY DATES FOR TRANSITIONING TO NC MEDICAID MANAGED CARE

The following list includes key dates that providers should be aware of:

- **March 15, 2021** – **May 21, 2021** – Beneficiary Open Enrollment
- **May 22, 2021** – Auto Enrollment Processes began
- **June 1, 2021** – Health plan brokers began scheduling Non-Emergency Medical Transportation (NEMT) appointments for July 1, 2021, or later
- **June 12, 2021** – Date by which all health plans completed distribution of member information and card to beneficiaries entering NC Medicaid Managed Care effective July 1, 2021.
- **July 1, 2021** – NC Medicaid Managed Care launch
- **Sept. 29, 2021** – Last date by which the health plan must honor existing and active prior authorizations on file with North Carolina Medicaid or NC Health Choice (or until the end of the authorization period, whichever occurs first)
- **Sept. 30, 2021** – End of beneficiary choice period to change PHP. *Exempt beneficiaries can change their health plan at any time. They can request to be moved to NC Medicaid Direct at any time. *Beneficiaries can change their health plan at any time for with cause reasons.
- **Nov. 30, 2021** – End of beneficiary choice period to change PCP. Beneficiaries shall be allowed to change their AMH/PCP without cause up to one time per year thereafter (2nd instance).
- **Nov. 30, 2021** – Last date by which the health plan will pay claims and authorize services for Medicaid-enrolled out-of-network providers equal to that of in-network providers.

KEY REMINDERS FOR PROVIDERS

All providers are strongly encouraged to complete the following checklist of key actions after NC Medicaid Managed Care Launch. More information on some of these items are detailed in the following pages.

- Make sure staff know the health plans with which you are contracted, and if you are an Eastern Band of Cherokee Indians (EBCI) Tribal Option provider.
- Continually review the NCTracks provider record for each applicable individual provider and organization for accuracy and submit changes using the Manage Change Request (MCR) process. Know where you need to submit claims.
- For each health plan under contract, please ensure enrollment in the Health Plan's Electronic Funds Transfer program is completed.
- Assist your beneficiaries with their transition to NC Medicaid Managed Care following the guidance below.

PROVIDER CONTRACTING REMINDERS

Health plan contracting is an ongoing process. If your office did not meet the deadline to be included in the initial launch of the Medicaid and NC Health Choice Provider and Health Plan Look-up Tool and health plan provider directories, there is still the opportunity to contract with each health plan. Explore your options with more information available here.

ENSURE YOUR INFORMATION IS CORRECT

Medicaid and NC Health Choice participating providers are contractually required to update their NCTracks record within 30 days of any change. This obligation to report includes any change in the 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 in compliance and maintain the accuracy of information supplied to the health plans and beneficiaries, take the time to regularly review your provider record in NCTracks. Changes may be submitted using the MCR process available in the NCTracks Secure Provider Portal.

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

Confirm that individual providers are correctly affiliated to organizations billing on their behalf and to each appropriate location within that organization. This is not only vital for claims adjudication, it is essential to ensuring that complete and accurate information will display in the NC Provider & Health Plan Look-Up tool and PHP Provider directories. When a beneficiary 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 WHERE TO SUBMIT CLAIMS

If there are claims for dates of service prior to July 1, 2021, they should be submitted as they are today, through NCTracks or LME-MCOs. A limited set of services are carved out of managed care and should continue to be billed through NC Tracks. These include dental services, eyeglasses, and Child Development Services Association (CDSA) services included on an Individualized Family Service Plan (IFSP) provided by independent practitioners.

For dates of service beginning July 1, 2021, claims routing depends on a beneficiary'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. Claims for members enrolled in Medicaid Managed Care should be submitted to the assigned health plan as shown on their member ID card and validated through the NCTracks Recipient Eligibility Verification methods, unless the service provided is a carved-out service.

Two Claims Submission Provider Fact Sheets are available on the Provider Playbook that addresses how managed care claims are filed.

ASSIST YOUR BENEFICIARIES WITH THE TRANSITION

As a provider, it is important that all office staff know which plans you participate with and to take the initiative to assist your patients with the transition to managed care. Please note:

- Beneficiaries have 90 days after the effective date of initial enrollment to change their health plan for any reason. In year one, most beneficiaries will have until Sept. 30, 2021, to change their health plan for any reason. In addition, beneficiaries shall be allowed to change their health plan with cause at any time.
- Beneficiaries have 30 days from the effective date of the AMH assignment (regardless of the notification date) to change their AMH/PCP without cause (1st instance) and shall be allowed to change their AMH/PCP without cause up to one time per year thereafter (2nd instance). In addition, Members shall be allowed to change their AMH/PCP with cause at any time. In year one, most beneficiaries will have until Nov. 1, 2021 to change their PCP/AMH for any reason.

- Within eight days of being enrolled with a health plan, beneficiaries should receive their Member Welcome Packet, Member Handbook, and Medicaid Card from their health plan. Follow these steps when a Medicaid or NC Health Choice beneficiary presents at your office:
    - Verify eligibility, health plan and primary care provider enrollment using the NCTracks Recipient Eligibility Verification/Response or calling the NCTracks Call Center for more information: 800-688-6696. To mitigate any confusion associated with newly issued Medicaid Managed Care member ID cards, providers and pharmacies should always use NCTracks Recipient Eligibility Verification/Response to confirm eligibility and not rely solely on the information shown on a Member ID Card.
        - Health plans are required to generate an identification card for each Member enrolled in their health plan that contains the Member's North Carolina Medicaid or NC Health Choice Identification number. Some health plans also include their health plan member ID as well. However, member ID cards are not required to provide service, and this includes pharmacies as well. **Therefore, members should not be turned away due to the lack of a Member ID card in their possession.**
    - Confirm that your office participates with the member's health plan.
    - If you are not the assigned Primary Care Practice for the beneficiary but are in-network for the health plan, you can render and be paid for Primary Care Services.
    - If the beneficiary would like to have you as their assigned Primary Care Practice, they should call their health plan to have them reassigned to you
    - If you are a non-participating provider for the beneficiary's Medicaid health plan, you may render services. Special protection is afforded non-network providers (see the Transition of Care section below). If a good-faith contracting effort has been made by the health plan and you declined to participate, then you are subject to receiving 90% of the Medicaid fee-for-service rate. If no good-faith contracting effort has occurred, or if it is in progress, then you are subject to receiving 100% of the Medicaid fee-for-service rate until the contracting effort has been resolved.

TRANSITION OF CARE PROTECTIONS IMPACTING PROVIDERS

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

Please note:

- The PHP will honor existing and active prior authorizations on file with the North Carolina Medicaid or NC Health Choice program for services covered by the health plan for the first 90 days after launch (Sept. 29, 2021) or until the end of the authorization period, whichever occurs first.
- For the first 60 days after Launch (Aug. 30, 2021), the health plan will pay claims and authorize services for Medicaid-enrolled out-of-network providers equal to that of in-network providers until end of episode of care or for 60 days, whichever is less (extended transition periods may apply for circumstances covered in N.C. Gen. Stat. § 58-67-88(d), (e), (f), and (g).).
- If a member transitions between health plans after July 1, 2021, a prior authorization authorized by their original health plan will be honored for the life of the authorization by their new health plan
- Additional transition of care-specific guidance will become available at: https://medicaid.ncdhhs.gov/transformation/care-management/transition-care

WHAT IF BENEFICIARIES HAVE QUESTIONS?

DHHS posted a What Beneficiaries Need to Know on Day One Fact Sheet to address common beneficiary questions about the transition to NC Medicaid Managed Care. Once a beneficiary is enrolled with a health plan, information and a new Medicaid card will be mailed within eight days. During crossover in year one, all health plans were required to distribute their welcome packet by June 12, 2021. If beneficiaries have questions about their health plan, want to change their PCP/AMH, 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 new Medicaid card or on the NC Medicaid website here.

Beneficiaries that want to change their health plan should call the Enrollment Broker Call Center which is open from 7 a.m. to 5 p.m., Monday through Saturday. To change a health plan through the Enrollment Broker, beneficiaries can:

- Call 833-870-5500, (TTY: 833-870-5588)
- Go online at ncmedicaidplans.gov
- Complete and return a paper enrollment form by fax or mail
- Use the NC Medicaid Managed Care mobile app

In addition, DHHS has partnered with Legal Aid of North Carolina to serve as the **NC Medicaid Ombudsman** to help resolve beneficiary complaints. Beneficiaries should contact the **NC Medicaid Ombudsman** at ncmedicaidombudsman.org or 877-201-3750.

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. 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 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 an MCR.