Ensuring Continuity of Care when A Beneficiary Transitions from Standard Plan to Medicaid Direct

Provider Office Hours Series

8/26/2021

Revised, v2

Transition of Care Vision

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

Ongoing Transition of Care: The NC Transition of Care "Tridge"

Health Plan 1

Health Plan 2

NC Medicaid Direct/Tribal/Local Management Entities – Managed Care Organizations (LME-MCO)

- Enrolling
- Disenrolling
- Tailored Plan eligible

Today's Focus:

- ❑ Confirming key populations who will disenroll from Standard Plan to Medicaid Direct
- ❑ Provide short-term and long-term approach to managing medical and pharmacy Prior Authorizations (PAs) for these beneficiaries.
- ❑ Provide update and guidance on in the Request to Move process.

Key NC Medicaid Beneficiary Groups who Will Disenroll from Standard Plan to Medicaid Direct upon Meeting Any of the Following Criteria

- Dually Eligible for Medicare/Medicaid.
- Enroll in waiver services or PACE.
- Enroll in Foster Care.
- Extended nursing facility stay (beyond 90 days)
- Requires a service only available in LME/MCO or otherwise meets “Tailored Plan eligibility.”
- List is not exhaustive. For full list, please see NC Medicaid Managed Care Enrollment Table in Reference section.
- Please see PA qualifier.*

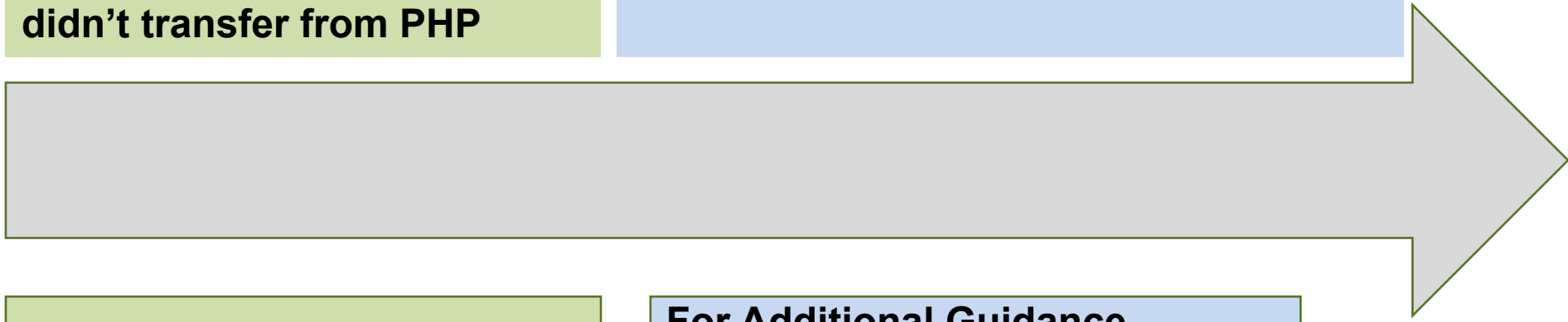
* There will be circumstances when the beneficiary's new status renders the current PA moot (e.g. Medicare becomes primary payer). Provider should be aware of how status change impacts applicability of existing PAs.

Prior Authorizations for Beneficiaries Transitioning from Standard Plan to Medicaid Direct: Short-Term Need and Long-Range Design

Transferring ("Inbound") PAs: Short-Term Needs and Long-Term Design

Short-Term Need
For covering services that require a PA with effective date on and after the beneficiary's transition date, **provider may need to (re)submit PA, if didn't transfer from PHP**

Long-Range Design
Unless expressly excluded from PA file transfer requirements, open PAs for transitioning members will transfer to Medicaid Direct.



Short-Term Safeguards
State will allow retroactive review of PAs if not already allowed.

For Additional Guidance
Prior Authorizations Covered When a Beneficiary Transitions to NC Medicaid Direct, August 4, 2021 Bulletin

Transferring PAs: Short-Term Need Overview

Short –Term Need: Why might providers need to submit PAs for transitioning members right now?

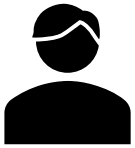
- Due to time-limited PA flexibilities that have been established to support providers and beneficiaries transitioning from Medicaid Direct → Standard Plan, there will be circumstances where the beneficiary's Standard Plan "waives" a PA requirement for a service the beneficiary uses while enrolled in a Standard Plan.

- To ensure beneficiaries and providers do not experience service disruption, providers should assess whether they will need to submit a PA directly to appropriate Medicaid Direct UM Vendor.

Flexibilities to Support this Short-Term Need: Expanded Retroactive Review Flexibilities for PAs

- State is leveraging federal flexibilities to enable those Clinical Coverage Policies that do not currently allow retro review to do so for beneficiaries disenrolling back to Medicaid Direct.
- Medicaid Direct staff and UM Vendors are authorized to retroactively review authorization requests the provider submits up to the last day of the month following the month of the beneficiary's transition date for the dates of service in which the beneficiary is enrolled in Medicaid Direct.
- This flexibility only applies to beneficiary's who have recently transitioned to Medicaid Direct.
- Can only review dates of service (DOS) when the beneficiary is covered by Medicaid Direct.
- This flexibility will remain in place until communicated by NC Medicaid with 30 days advance notice.

Short Term Need: Design Overview



July 1, 2021

Beneficiary transitions to Standard Plan. The Standard Plan has established PA flexibilities to support members and providers at Crossover.

September 1, 2021

Beneficiary hits an excluded category status and transitions back to Medicaid Direct. Due to PHP flexibility, no PA for needed service has transferred.

September 15, 2021

Provider doesn't realize beneficiary has transitioned to Medicaid Direct and needs to submit a PA for service for Dates of Service while beneficiary in Medicaid Direct, back to September 1, 2021. Provider may submit PA request with effective date back to September 1, 2021 if otherwise appropriate (and would be authorized to submit for retro review until 10/31/2021).

Long-Range Design Overview

Long-Range: Design Overview

November, 2021

Beneficiary in Standard Plan and has current authorization that will transfer* to Medicaid Direct with end date of January 5, 2022.

November 30, 2021

Having received notice on eligibility file that beneficiary is disenrolling, Standard Plan sends open PA to NCTracks.

December 1, 2021

Beneficiary's new status results in disenrollment from Standard Plan and return to Medicaid Direct. Standard Plan PA is now available for beneficiary and provider through NCTracks.

January 5, 2022

Standard Plan transferred PA hits end date. If additional service authorization required, submit to Medicaid Direct UM Vendor.

* See list on Long-Term Design: What PAs Will Transfer from Standard Plan?

Long-Term Design: What PAs Will Transfer from Standard Plan?

YES

Durable Medical Equipment	Medicaid for Pregnant Women	Transplants
Hearing Aid	Early Routine Eye Exam	Exception to Legislative Limits
Hospice	Outpatient Psychiatric	Auditory Implants
Out of State	Psychiatric Services	PCS Combined—In-Home Care & Adult Care Home. **BUT SEE NOTE**
Out of State Surgery	Specialized Therapies	Pharmacy
Surgery	Radiology	Standard Plan PAs for services managed by LME/MCO will transfer to LME/MCO unless consent to transfer is required and not secured
Private Duty Nursing	Home Health	

NO

Nursing Facility (LTC)	Please see Nursing Facilities Supporting NC Medicaid Only Residents Enrolled in NC Medicaid Managed Care: Prior Authorizations on June 29, 2021,
Contact Lenses	Please see in Prior Authorizations for Medically Necessary Contact Lenses When a Beneficiary Transitions NC Medicaid Direct.

PCS NOTE: While Personal Care Services (PCS) PAs will transfer, please also see Personal Care Services Beneficiary Managed Care Disenrollment Process and Updated Referral Form on July 17, 2021 for supplemental guidance on how the PA process will be managed.

Long Range Design: Special Scenarios

If a Standard Plan transfers an authorization for a service that does not require a PA in NC Medicaid Direct.

In this scenario, the transferred PHP-generated PA will be irrelevant and not required in order for applicable claims to pay.

The provider will not be required to resubmit an authorization.

Examples include: Radiology and Transplants

If a Standard Plan has authorized a service for more units than allowed under the applicable Clinical Coverage Policy.

NCTracks claim edits will only allow payment up to the limit under the applicable Clinical Coverage policy.

If a Standard Plan transfers a PA for a service not covered under NC Medicaid Direct.

A beneficiary will not receive this service in NC Medicaid Direct, unless the non-covered service is approved for beneficiaries under the age of 21 under the EPSDT benefit or per the Home Health Final Rule at 42 CFR, part 440.70.*

Fee-for-service claims submitted for a service authorized by a PHP but not covered under NC Medicaid Direct will deny, unless the corresponding PA has been authorized under the EPSDT benefit or per the Home Health Final Rule at 42CFR, part 440.70.*

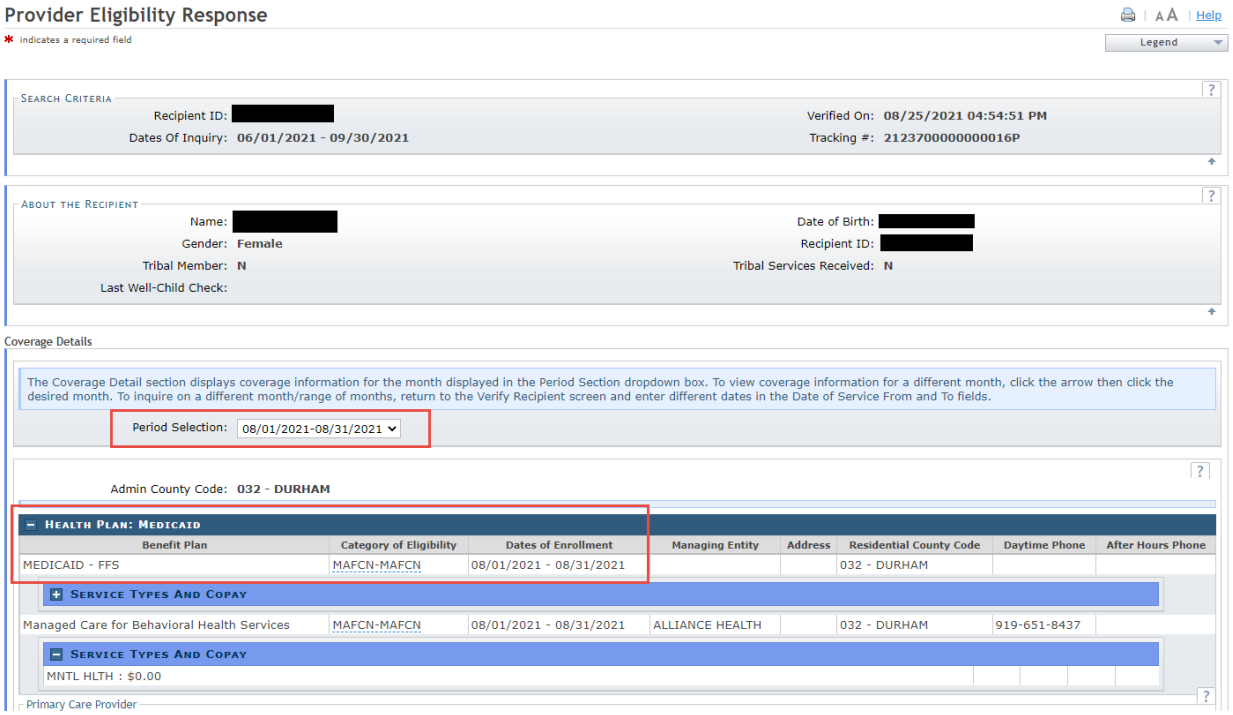
* If PHP PA was authorized under 42 CFR part 440.70 authority, provider will be required to resubmit until functionality is updated.

Inbound PA Management: Key Good Habits

- [x] Always check beneficiary's current eligibility and managed care status before submitting a PA.

- [x] Check NCTracks to confirm if PA already available.

Always check beneficiary's current eligibility and managed care status before submitting a PA.



Provider Eligibility Response

Help

* indicates a required field

Legend

SEARCH CRITERIA

Recipient ID: [redacted]

Dates Of Inquiry: 06/01/2021 - 09/30/2021

Verified On: 08/25/2021 04:54:51 PM

Tracking #: 2123700000000016P

ABOUT THE RECIPIENT

Name: [redacted]

Gender: Female

Tribal Member: N

Last Well-Child Check:

Date of Birth: [redacted]

Recipient ID: [redacted]

Tribal Services Received: N

Coverage Details

The Coverage Detail section displays coverage information for the month displayed in the Period Section dropdown box. To view coverage information for a different month, click the arrow then click the desired month. To inquire on a different month/range of months, return to the Verify Recipient screen and enter different dates in the Date of Service From and To fields.

Period Selection: 08/01/2021-08/31/2021

Admin County Code: 032 - DURHAM

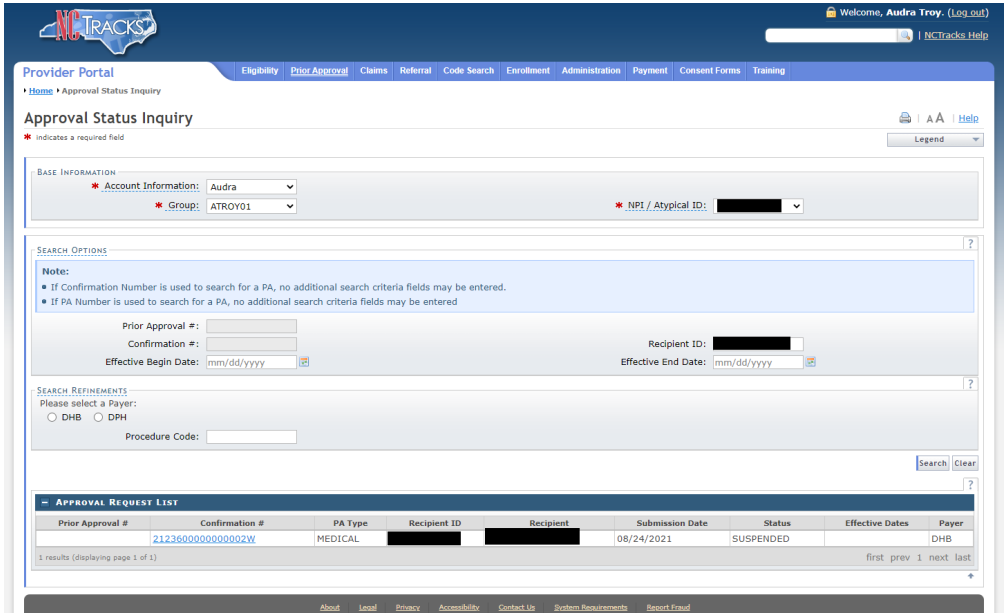
HEALTH PLAN: MEDICAID

Benefit Plan	Category of Eligibility	Dates of Enrollment	Managing Entity	Address	Residential County Code	Daytime Phone	After Hours Phone
MEDICAID - FFS	MAFCN-MAFCN	08/01/2021 - 08/31/2021			032 - DURHAM		
SERVICE TYPES AND COPAY							
Managed Care for Behavioral Health Services	MAFCN-MAFCN	08/01/2021 - 08/31/2021	ALLIANCE HEALTH		032 - DURHAM	919-651-8437	
SERVICE TYPES AND COPAY							
MNTL HLTH : $0.00							

Primary Care Provider

Providers should check NCTracks to confirm a beneficiary's eligibility and NC Medicaid Managed Care status before submitting any PA request. This can be checked through the NC Tracks Provider Portal by selecting "Inquiry" under Eligibility Tab. If a beneficiary has transitioned to NC Medicaid Direct for date span selected in "Period Selection," the Benefit Plan field in the Provider Portal will display "Medicaid-FFS" and the Managing Entity field will be blank.

Check NCTracks to Determine if PA already Available Inquiry in NC Tracks



To perform inquiry, user selects PA Inquiry under the Prior Approval tab and enters the PA details - typically PA number or recipient ID and select Search. All matching results will appear in the Approval Request List; provider can select individual record to see PA details. For PAs transferred from PHP to NCTracks, provider will be able to view as long provider NPI is on the PA as the requesting, billing, or rendering provider. NCTracks PAs created from PHP will look no different from PA that originated in NCTracks during portal inquiry.

Request to Move Process: Overview and Updates

What if, after July 1, 2021, a Member Needs a Behavioral Health Service That is not Covered by Standard Plans?

A provider can request a transfer to NC Medicaid Direct and LME-MCO if a member needs a behavioral health or Intellectual or developmental disabilities (I/DD) service that is *not* covered by Standard Plans.

Provider Works with Member to Complete the Request

Member and provider discuss which services member needs that are not available in current plan.

Member or Legal Guardian Signs the Request

Member or guardian confirm the member wants to immediately disenroll from the Standard Plan.

Provider Submits the Request

Provider submits the provider form and a service authorization form to the Enrollment Broker, which will send to appropriate Vendor within 24 hours.

NC Medicaid Reviews the Request and Transfers Member

NC Medicaid reviews the request and, if approved, transfers member to new plan within 1 business day.

Service Associated & Non-Service Associated Requests

- A Service Associated Request is a **provider** submitted by the provider who will provide the request service.
  - Request to Move Form + Service Authorization Request and Supporting Documentation.
  - Beneficiary's disenrollment date from the Standard Plan is retroactively applied back to the date of the request.

- A *Non-Service* Associated Request is submitted by a **provider** or **beneficiary**
  - Submitting provider doesn't have to be the provider who will provide ongoing service (e.g. Hospital staff may submit).
  - A non-service associated request does not include a service authorization request for services and is either submitted directly by a Beneficiary (utilizing the *Request to Move to NC Medicaid Direct (Fee for Service) or LME-MCO: Beneficiary form)* or by a Provider with the Member's consent.
  - Non-service associated requests are reviewed within 8 business days for Beneficiary forms and 5 business days for Provider forms.

How Do You Submit the Forms?

The *Request to Move to NC Medicaid Direct (Fee for Service) or LME-MCO forms* can be submitted digitally via the website ncmedicaidplans.org or by calling the Enrollment Broker at 1-833-870-5500 to request a downloadable form version that can be mailed or faxed.

Request to Move to NC Medicaid Direct (Fee for Service) or LME-MCO: Beneficiary form - https://ncmedicaidplans.gov/sites/default/files/Documents/NC_Medicaid_Direct_Transition_Form_Beneficiary_ENG_v04WEB_062821.pdf

Request to Move to NC Medicaid Direct (Fee for Service) or LME-MCO: Provider form - https://ncmedicaidplans.gov/sites/default/files/Documents/NC_Medicaid_Direct_Transition_Form_Provider_ENG_v05WEB_062821.pdf

Online Submission: https://ncmedicaidplans.gov/submit-forms-online

Request to Move Process: Important Notes

- Requests to Move process is only available to support beneficiaries who require services provided by the LME/MCO (i.e. behavioral health, I/DD). It is not a vehicle for a member to return to Medicaid Direct if not otherwise “Tailored Plan eligible.”
- Provider submitting a Service Associated Request to Move form should provide the necessary Service Authorization Request and supporting documentation.
- Standard Plans are responsible for covering the expense of Assessment costs that may be incurred prior to disenrollment

Reference Slides

NC Medicaid Managed Care Enrollment Table

Status of Medicaid Managed Care Enrollment, Per Legislation	Populations
Mandatory (Must enroll)	• Most family & children's Medicaid, NC Health Choice, pregnant women, non-Medicare aged, blind, disabled
Excluded (Cannot enroll, stays in NC Medicaid Direct)	• Family Planning program, medically needy, health insurance premium payment (HIPP), Program of All-inclusive Care for the Elderly (PACE), refugee Medicaid • Some beneficiaries are temporarily excluded and become mandatory later. This includes dually-eligible Medicaid/Medicare, foster care/adoption, & Community Alternatives Programs for Children (CAP/C) and Disabled Adults (CAP/DA).
Exempt (May enroll or stay in NC Medicaid Direct)	• Federally recognized tribal members, beneficiaries who would be eligible for behavioral health tailored plans (until they become available). Target launch date for Tailored Plans is July 1, 2022.

Additional Information about Request to Move Process

Non-Service Associated Requests: Submission and Review

The Beneficiary or Provider will digitally submit the form through the website ncmedicaidplans.org, or mail or fax the form to Enrollment Broker.

1. The Enrollment Broker sends the form to be reviewed and processed by the Department designee.
2. The Department designated reviewer makes a determination of BH I/DD Tailored Plan Eligibility
    - If a non-service associated request is denied, the Department designated reviewer sends the beneficiary notice with their appeal rights
3. Department designated reviewer notifies the Enrollment Broker and State Eligibility team of approval. The State Eligibility team updates the Beneficiary's BH I/DD Tailored Plan Eligibility.
4. The Enrollment Broker sends the Beneficiary a notice with NC Medicaid Direct enrollment information.

If a Beneficiary has a question on the status of their non-service associated requests, you can direct them to call the Enrollment Broker toll-free at 1-833-870-5500 and select Option 5 in the IVR.

Service Associated Requests: Submission and Review

1. The Provider will digitally submit the form through the website, or mail or fax the form and include additional necessary documentation to Enrollment Broker.

2. The Enrollment Broker will contact the LME-MCO via secure email by sending the service associated request and necessary documentation. The EB also sends an alert the Department's Eligibility Services Team at the same time.
    - If the beneficiary has North Carolina Health Choice (NCHC), ages 0-3, or is a Fully Qualified Legal Immigrant, the form will instead be reviewed and processed by the Department designee.

3. The LME-MCO will complete the review of the final service authorization request. (The Enrollment Broker will not provide any review of any underlying service authorization requests.)
    - If the LME-MCO does not approve the SAR, the member will transition to the LME-MCO even if the SAR is denied. For service associated requests, the submission of the request alone is seen as evidence for Tailored Plan eligibility.

LME-MCO & Medicaid Direct Only Services

Medicaid Behavioral Health Services Excluded from the Health Plan Benefit

- Residential Treatment facility services for children and adolescents
- Child and adolescent day treatment services
- Intensive in-home services
- Multi-systemic therapy services (MST)
- Psychiatric residential treatment facilities (PRTF)
- Assertive community treatment (ACT)
- Community support team (CST)
- Psychosocial rehabilitation (PSR)
- Substance abuse non-medical community residential treatment
- Substance abuse medically monitored residential treatment
- Substance Abuse Intensive Outpatient (SAIOP)
- Substance Abuse Comprehensive Outpatient Treatment (SACOT)
- Intermediate care facilities for individuals with intellectual disabilities (ICF/IID)
- Innovations Waiver services*
- Traumatic Brain Injury Waiver services*
- 1915(b)(3) services
- State-Funded Behavioral Health and Intellectual and Developmental Disability Services

These services are only available in NC Medicaid Direct and through the LME-MCOs

LME-MCO & Medicaid Direct Only Services

1915(b)(3) Services

- Respite
- Supported Employment / Employment Specialist
- Individual Support
- One-time Transitional Costs
- NC Innovations Waiver services
  - Funded by (b)(3)
  - Deinstitutionalization services
- Community Navigator
- In-home Skill Building
- Transitional Living Skills
- Intensive Recovery Support

These services are only available in NC Medicaid Direct and through the LME-MCOs

LME-MCO & Medicaid Direct Only Services

State-Funded Behavioral Health and I/DD Services

- Certain behavioral health and I/DD services are available for individuals who are uninsured or who do not have adequate insurance and are supported by state and federal funds.
- These services are available through LME-MCOs and vary by LME-MCO
- Examples of these services include but are not limited to:
  - Substance use halfway house
  - Developmental Therapy
  - Residential supports
- The full state-funded services list is accessible at:

https://files.nc.gov/ncdhhs/state-funded%20MHDDSAS%20Service%20Definitions%202003-2017%20effective%202017-1-17.pdf

These services are only available through the LME-MCOs