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Network Communication Bulletin #221

To: All Providers

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Date: June 09, 2022

Subject: NC Medicaid Managed Care Provider Update

SPECIAL BULLETIN MEDICAID TRANSFORMATION

NC MEDICAID MANAGED CARE PROVIDER UPDATE

UPCOMING KEY MILESTONE DATES FOR NC MEDICAID MANAGED CARE

Date	Key Milestones
June 15, 2022	Tailored Plan Member and Provider Services lines go-live
June 15, 2022	Enrollment Broker provider directory updated to include Tailored Plan providers
June 15, 2022	Healthy Opportunities Pilot toxic stress and cross-domain services launch
July 16, 2022	Last day for providers to have fully executed contracts with PHPs for inclusion in the first day of the beneficiary choice period.
Aug. 1, 2022	Beneficiaries will be assessed to confirm qualification for Tailored Plan. Beneficiaries that no longer qualify will receive a notice from the Enrollment Broker about their choices
Aug. 15, 2022	Tailored Plan Auto-Enrollment begins. Enrollment Broker begins mailing Enrollment Packets to beneficiaries
Aug. 15, 2022	Beneficiary Choice Period begins; Beneficiaries can choose a primary care provider (PCP) and Tailored Care Management provider by contacting their Tailored Plan
Sept. 15, 2022	Last day for PCPs to have fully executed contracts with PHPs for inclusion in PCP Auto-Assignment
Sept. 30, 2022	Last day for Tailored Care Management providers to have fully executed contracts with PHPs for inclusion in Tailored Care Management Auto-Assignment
Oct. 14, 2022	Last day for beneficiaries to choose a PCP and Tailored Care Management provider before auto-assignment

Date	Key Milestones
Post-Oct.14, 2022	PCP and Tailored Care Management Provider Auto-Assignment (by Tailored Plan) for beneficiaries who have not chosen a PCP or Tailored Care Management provider
Oct. 22, 2022	Tailored Plans begin mailing Welcome Packets to beneficiaries
Nov. 1, 2022	Tailored Plan Pharmacy, Nurse, and Behavioral Health Crisis lines go live
Dec. 1, 2022	Behavioral Health and Intellectual/Developmental Disabilities (I/DD) Tailored Plans launch

Provider Playbook Updates

The Provider Playbook is a collection of information and tools specifically designed to assist providers transitioning to NC Medicaid Managed Care. The latest resources are added to the fact sheet page.

- Tailored Plan Provider Contracting Deadlines Questions and Answers – An overview of frequently asked questions regarding providers and PHP's during the contracting and auto-assignment process
- Contracting with Tailored Plans – An overview of key dates, reminders and links to assist providers and their beneficiaries before the Tailored Plan launch
- Plan to Plan Disenrollment – Provides guidance & scenarios for beneficiaries on possible changes between plans
- Tailored Plan Auto-Enrollment & Opt-In Scenarios – An overview of key dates, reminders and links to assist providers before the auto-enrollment deadline

Verifying NC Medicaid Eligibility for Beneficiaries

Providers are reminded to verify eligibility, health plan and primary care provider enrollment as beneficiaries present at the office for care and prior to rendering services using the NCTracks Recipient Eligibility Verification/Response. Member ID cards are not required to provide services, including pharmacies, so members should not be turned away due to the lack of a Member ID card in their possession. Upon discovery that a beneficiary is not eligible for Medicaid, the practice should refer the beneficiary to the county DSS agency for assistance.

For more information, see the fact sheet What Providers Need to Know: Part 2 – After Managed Care Launch or the Confirming Medicaid Coverage for Beneficiaries bulletin.

Provider Reverification

As the federal Public Health Emergency (PHE) comes to an end, providers will begin receiving reverification notices again. These notices will be sent to providers with approaching reverification due dates, as well as those whose reverification was suspended during the PHE. For more information, see Provider Reverification Requirements to be Reinstated.

IMPORTANT: Verify Your NCTracks Provider Record is Current

Providers are contractually obligated to maintain their NCTracks provider enrollment information. This includes ensuring that the designated Office Administrator and all email addresses on the provider record remain current so designated personnel may receive and respond to notifications.

Providers may review the information on their NCTracks record by initiating a Manage Change Request from the Status and Management page of the secure Provider Portal. For assistance with reporting changes through the NCTracks Manage Change Request, providers should reference the NCTracks Provider User Guides and Training tools, or contact the NCTracks Call Center at 800-688-6696.

REMINDER: Coverage for Pregnant Beneficiaries Extended to 12 Months

As of April 1, 2022, NC Medicaid coverage for pregnant beneficiaries is extended to the last day of the month in which the 12-month postpartum period ends. The change is made pursuant to NC Senate Bill 105 Session Law 2021-180 Section 9D.13 and the American Rescue Plan Act of 2021. These laws are in effect through March 31, 2027.

Detailed information is available in Medicaid bulletin article Medicaid for Pregnant Beneficiaries Extended to 12 Months After Birth.

COVID-19 Vaccine Incentive Program

The fact sheet covering the Vaccine Incentive Program has been updated and posted to the NC Medicaid COVID-19 Guidance and Resources Page. The fact sheet provides a summary of each Standard Plan COVID-19 Member Incentive Program and links to more detailed information on the Standard Plan member incentives.

Provider Ombudsman

Each health plan has a grievance and appeal process for providers, separate from the process for beneficiaries, which can be found in each health plan's Provider Manual, linked on the Health Plan Contacts and Resources Page.

The Provider Ombudsman service is separate from the Health Plans' Provider Grievances and Appeals process and should be used as an escalation after contacting Health Plans and searching the NC Medicaid Help Center.

Inquiries may be submitted to Medicaid.ProviderOmbudsman@dhhs.nc.gov or by calling the NC Medicaid Managed Care Provider Ombudsman at 866-304-7062.

Help Center Available for Providers to Find Information

The NC Medicaid Help Center is an online source of information about Managed Care, COVID-19 and Medicaid and behavioral health services, and is also used to view answers to questions from the NC Medicaid Help Center mailbox, webinars and other sources. To use this new tool:

1. Go to NC Medicaid Help Center
2. Type a topic or key words into the search bar
3. Select a topic from the available list of categories

Detailed information about the NC Medicaid Help Center is available in a Medicaid Bulletin updated on June 17, 2021.

PHP Quick Reference Guides

NC Medicaid's Managed Care Prepaid Health Plans (PHPs) created quick reference guides to include the most current and comprehensive information for providers.

The PHP quick reference guides are available on the Provider Playbook Fact Sheet webpage under the Health Plan Resources section. Links to the health plan training webpages have also been added to the Provider Playbook Training Courses webpage.

NC Medicaid Managed Care Webinars

Visit the AHEC Medicaid Managed Care webpage for additional information and registration for upcoming webinars, as well as recordings, slides and transcripts from previous webinars.

Read the original article NC Medicaid Managed Care Provider Update - June 7, 2022

PRIOR APPROVAL (PA) REQUIREMENTS RESUME FOR CHILDREN'S DEVELOPMENTAL SERVICES AGENCY PROVIDERS

- PA Requirements Resume for Children's Developmental Services Agency Providers

Effective July 15, 2022, behavioral health services provided by Children's Developmental Services Agencies (CDSAs) and direct-enrolled providers in accordance with an individualized family service plan (IFSP) are **required to resume the submission of prior approval (PA) requests to Beacon Health Options.**

PA requests shall be submitted in accordance with the requirements outlined in clinical coverage policy 8J, Children's Developmental Services Agencies:

Prior Approval Requirements for Outpatient Specialized Therapies

Refer to **Section 5.0** of clinical coverage policies 8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers for details on prior approval requirements for these services.

PA is required for medical approval only and must be obtained before rendering a service, product or procedure that requires PA. Obtaining PA does not:

- Guarantee payment
- Ensure beneficiary eligibility on the date of service; or
- Guarantee that a post-payment review that verifies a service medically necessary will not be conducted

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Any questions about this Communication Bulletin *that does not already have an email listed for questions from that specific section*, may be sent to the following email: NetworkManagement@TrilliumNC.org. These questions will be answered in a Q&A format and published on Trillium's website.