2024 LTSS Provider Forum Q&A Session: MANAGED CARE

Answers provided and vetted by DHB 7/22/2024

Can we get the list of panelists and their contact info that were here representing each MCO? Yes

Healthy Blue managed care are recouping payments made to providers of pcs saying that Medicaid retro disenrolled them. Meanwhile, authorization for the services was given, in take assessments, done and Aides paid. And Healthy blue has gone a step further in recouping monies from other members still enrolled in the plans. Meaning that the agency is providing care for free to healthy blue because the agency had to pay the Aide out of pocket. This particular recipient cannot be abandoned because of her present health condition. Please help. Contact Provider Ombudsman.

Will managed care plans publish assessment results similar to pcs monthly report from QiReport? No

What does a provider need to qualify to become a provider for the Tailored Plans? Contact Tailored Plans for contracting.

Is there a documented process for reimbursement for a member who is retroactively disenrolled from managed care back to NC Medicaid Direct? Contact the Provider Ombudsman.

Does "raise your hand" allow moves from TP-> Standard, Standard-> TP, are there ANY raise your hand situations that would allow a NON-DUAL eligible move to Medicaid Direct? No

"Did I understand correctly that a provider can send a 3051 to NCLIFTSS and they will get it where it needs to go including to a standard plan, Tailored Plan or NC Medicaid Direct? Is it possible for the plans to be responsible for the warm handoff before it becomes a recoupment and requirement for the provider to rebill? and follow Transition of care policy? The retroactive eligibility changes and plan changes are extremely complicated. It is SO important to standardize the process for all plans - including assessments, service plans and authorizations because of the number of moves and how autos and care docs follow". NCLIFTSS will forward the 3051 to Tailored Plans (only) and this process is to support the smooth transition into Tailored Plan and this accommodation is temporary.

Why can CAP have a family member to care for them and PCS cannot? Consumer Direction is only permitted by CMS using Waiver Authority and is not permitted for State Plan services.

Does that mean that CAP/DA will be moving to managed care program in the next couple of years? No decision has been made about the transition of 1915(c) Waiver beneficiaries into Managed Care.

What is included in the carve out plan? Currently individuals who are 1915(c)Waivers beneficiaries, PACE, dually eligibles, and foster Care are excluded from NC Medicaid Managed Care at this time.

Is PCS a rate floor service? No

How does an agency become enrolled or should I say become eligible to provide services to clients who have become enrolled in a Tailored Plan? Contact Tailored Plans for contracting.

Will direct Medicaid Members be affected by Tailored Plans?" Medicaid individuals who were determined to be Tailored Plan eligible were moved to Tailored Plan.

Dual eligibility will still be NC Medicaid Direct?" Yes

If you sent a 3051 to Carolina complete. do I need to send one to NCLIFTSS? No

How do clients qualify for managed care vs Tailored Plans? Do providers need to sign up with the Tailored Plans to become a provider? https://ncmedicaidplans.gov/en/learn

Will the standard MCOs, providers had some trouble getting authorizations within 90 days of roll out is there a plan to ensure this doesn't happen again? Medicaid has implemented several policy flexibilities to ease provider administrative burden at launch and ensure beneficiaries receive uninterrupted care. These flexibilities cover medical and pharmacy prior authorizations (PAs), out-of-network providers follow in-network PA rules and rates and primary care provider (PCP) changes.

"For Tailored Plan services, like the NC innovations waiver, what does an agency have to do to be fully able to provide the services that are within that waiver? For example, contract with the LME first, then what?" Contact Tailored Plans for contracting.

What are tailored plans? https://medicaid.ncdhhs.gov/tailored-plans

For the tailored plans, what do you know about available DME providers that have contracted with your plans? I have tried searching for DMEs on the provider search function with no luck and was trying to help a TPN-dependent patient, so this is life-sustaining for this person. I know they can continue to use their current provider until Jan 31 but they are obviously worried. https://medicaid.ncdhhs.gov/tailored-plans/moving-to-a-tailored-plan

"Transportation difficulties. What is being placed for improvements? Cancellations? Specifically Wellcare" Contact the NC Medicaid Ombudsman

Are the quarterly meetings virtual for members? Unable to respond.

Is there a plan to unify managers care authorizations? It is a challenge to interpret these authorizations because some are in units, hours, etc. as well as the length of times varies in weeks, months, etc. No

Can a beneficiary have both CAP as well as Tailored Plan? Will these two work collaboratively together or does a beneficiary choose only one? No, 1515(c) CAP Waiver beneficiaries are carved out of managed care at this time.

Can you please post all the links to the MAC Groups in one place? Yes

What is the manage care procedure for notifying the agency when a PCS beneficiary is disenrolled and return to Medicaid Direct. There's been multiple times the agency isn't notified resulting in delays of getting the 3051 form and thus payment for services. Have had

issues with all MC but UHC has been the only one that has notify us consistently. Contact Provider Ombudsman.

"Why aren't MCOs more proactive with assisting providers with eligibility changes? Beneficiaries that switch MCOs, or switch back to Direct, or turning 65 and no longer dual eligible. We had a provider that received a new referral in April that had turned 65 in February- should have never been sent to the provider because it was already NC Medicaid Direct at that time." Contact the Provider Ombudsman for assistance with resolving this issue.

What forms do we need your members to fill out for PCS and how do we access them? Or do we just tell them to contact you all? The process for enrolling in PCS varies depending on whether the individual is in NC Medicaid Direct or NC Medicaid Managed Care. For assistance contact NCLIFTSS.

Some of our providers have trouble connecting with case managers with MCOs to build relationships to get new clients. Is there a better way to contact case managers directly? Contact the health plans for additional guidance.

When will Plans be open to discuss value based contracts with groups of PCS providers? Unable to respond to this question.

"Will the rate per unit increase for PCS in next 90 days?" No

You mentioned "integrating CAP/C and PDN. Can you please elaborate? The CAP case manager is responsible for coordination between waiver and State Plan services.

We have a client that receives PDN services related to a diagnosis of SMA, a neuromuscular disorder. We were told he will be switching to a Tailored Plan. Are there certain diagnosis that place clients in the Tailored Plan automatically? I understood the Tailored Plan to be based on IDD, mental health, and substance abuse disorders. https://medicaid.ncdhhs.gov/tailored-plan-essentials-powerpoint/open

Will HOP expand the regions in the future? https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots

Will Tailored Plans be required to report outcome and other scoring comparison like PHPs and AMH+ and will that be available to other providers? Same question but from Tailored Plan to Standard Plan and back and forth? Unable to respond to this question.

Will the state do anything about PHPs OR Medicaid Direct noncompliance with policies like Transition of Care policies? Medicaid will monitor and enforce contract requirement for health plans.

Will all PHPs follow rate schedules? https://medicaid.ncdhhs.gov/day-one-provider-quick-reference-guide/open

Will a beneficiary be screened for at risk for LTSS and will those be sent to a HOP participating provider? Unclear about who is doing the screening, if the individual is enrolled in NC Medicaid Managed Care, then yes.

Will all PHPs be Tax ID based or NPI based? https://medicaid.ncdhhs.gov/day-one-provider-quick-reference-guide/open

What is the deal with retroactive eligibility erasing a managed care participation reflector? https://medicaid.ncdhhs.gov/day-one-provider-quick-reference-guide/open

With eligibility changes that occur retroactively will the payers resolve amongst themselves as opposed to imposing on the provider the responsibility to payback and then bill? Contact Provider Ombudsman.

Will the authorization utilization rules for PHPs be the same as Medicaid Direct? Not necessarily.

Will a DSNP program be available? No decision has been made about the enrollment of dually eligible individuals into NC Medicaid Managed Care.

Will billable diagnosis DX codes be the same for PHPs and TPs as they are for Medicaid Direct (which allows all ICD-10 billable codes)? https://medicaid.ncdhhs.gov/day-one-provider-quick-reference-guide/open

Will taxonomy codes from NCTracks be a SOURCE OF TRUTH? https://medicaid.ncdhhs.gov/day-one-provider-quick-reference-guide/open

Do the training requirements of Tailored Plans differ from the training requirements of NC Medicaid Direct? Unable to respond to this question, unclear about what "training requirements" the inquirer is referencing.

How should the provider resolve situations where the beneficiary's need level (e.g. limited, extensive, full) determined by a Tailored Plan varies from agency RN's determination of need level? For example, will DHSR rules control; will an appeal of some sort be required? Contact the Provider Ombudsman for assistance with resolving this issue.

Will the number of days per week authorized for PCS be a part of a Tailored Plan authorization? Yes

Will a home care agency RN be required to complete an assessment as contemplated in the DHSR Rules (10 NCAC 13J) with every new Tailored Plan authorization? Please contact DHSR.

Will providers serving a beneficiary in a Tailored Plan be a part of or participate in referral management, assessment scheduling, care plan/service plan preparation? Yes

Will NEMT appointments made today be made based on the admin county the beneficiary is assigned regardless of the Tailored Plan of their residential county? Beneficiaries should contact their health plan to schedule NEMT appointments. https://medicaid.ncdhhs.gov/nemt

Will TPL override be honored for PCS in Tailored Plan claim billing? Follow billing process provided by each TP.

Will portal access be made available by Tailored Plans regardless of Network Status for any amount of time? Contact Provider Ombudsman.

Will providers participating in a Tailored Plan be required to complete ARM or other HCBS Final Rule reporting? Contact Provider Ombudsman.

Will Tailored Plan assignment always trigger TCLI in person evaluations? If not, what are the criteria for triggering TCLI in person evaluations? https://medicaid.ncdhhs.gov/day-one-provider-quick-reference-guide/open

Will a beneficiary seeing a specialist not available in their Tailored Plan residential county be the subject of a single case agreement between two plans/payers in any case? https://medicaid.ncdhhs.gov/day-one-provider-quick-reference-guide/open

Will beneficiaries receive option counseling through all or any of the following: the enrollment broker, NN navigators, DSS, nccare360, case managers, volunteers, participating HOP providers, NCLIFTSS, 211 or SHIP? Depending on the definition of "options counseling" like all will provide some guidance.

Will 834 files or Managed Care disenrollment forms made available through NCLIFTSS result in the end of providers responsibility to alert Medicaid of disenrollment from a Managed care plan (ALL PHPS)? No

Will all Tailored Plan directories and any Tailored Plan vendors be updated automatically from updates in NCTracks provider files? Unable to respond to this question.

Will Tailored Plans and their vendors require any additional Credentialing requirements such as NCQA or enrollment certification currently done in NCTracks? https://medicaid.ncdhhs.gov/day-one-provider-quick-reference-guide/open

Will a standard plan offer the same services as a Tailored Plan in any in lieu of services? Not necessarily, each plan has discretion about what in lieu of services they offer.

Will services in a PCS authorization for Tailored Plans include services not billable through PCS in NC Medicaid Direct; such as errands? Perhaps, the Tailored Plan has the discretion to cover more services than NC Medicaid Direct.

Will authorizations be in the same format across all Tailored Plans for PCS? To be determined

Will providers need to upload or submit service records and if so how? Unable to respond to this question.

Will Tailored Care Management providers be the assessing entity for PCS at all within a Tailored Plan? If so, how will that be managed for Medicaid Direct dual eligibles (not TBI waiver, IDD or innovation waiver) receiving LME/MCO services with Tailored Care Managers but not in the Tailored Plan and the role of the comprehensive Independent Assessment entity under NCLIFTSS (Acentra)? Information outlining this will be forth coming.

Will the Tailored Care Management providers be doing comprehensive assessments that expand beyond criteria for PCS (based on clinical coverage policy 3L)? Likely yes, Tailored Plans have discretion to implement their own tools to conduct comprehensive assessment.

Were letters about Tailored Plan enrollment sent to people on the CAP waiting list? It depends on the individual's enrollment status, as an example if they were dually eligible, then no.

How many now on the waiting list for CAP services are anticipated to be in a Tailored Plan? Unknown

How many beneficiaries receiving PCS are anticipated to be in a Tailored Plan in an Adult Care Home or Family Care Home Setting? Information is being updated

How many beneficiaries receiving PCS are anticipated to be in a Standard Plan in an Adult Care Home or Family Care Home Setting? Information is being updated

How many beneficiaries receiving Personal Care Services are anticipated to be Standard Plan or in a Tailored Plan July 1, 2024? Information is being updated

Please describe any scenario in which a non-dual eligible would be allowed to move from a tailored plan or standard plan back to Medicaid Direct? Enrollment in PACE or 1915(c) CAP/C or CAP/DA.

Will people in a standard plan receiving PCS services be allowed to move plans more than once a year based on choice and participation in an LTSS program? No, not based on LTSS participation.